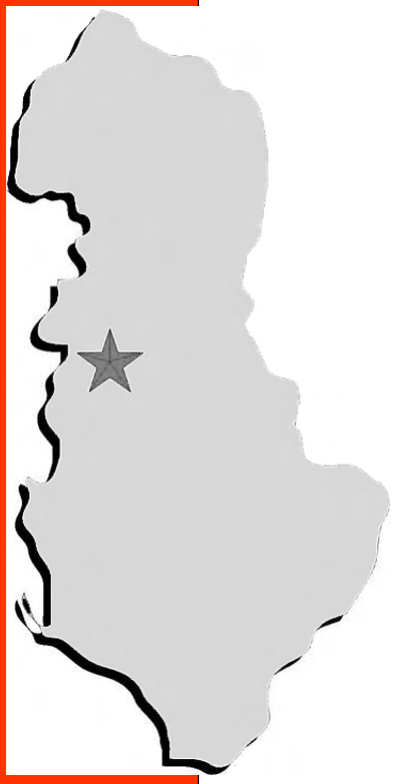

STRATEGIC APPRAISAL

USAID/ALBANIA HEALTH STRATEGY AND PORTFOLIO

ACHIEVEMENTS, OPPORTUNITIES AND A WAY FORWARD

HARRIETT DESTLER, TEAM LEADER
JOYCE HOLFELD
NATHAN BLANCHET

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USAID
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STRATEGIC APPRAISAL

USAID/ALBANIA HEALTH STRATEGY AND PORTFOLIO ACHIEVEMENTS, OPPORTUNITIES AND A WAY FORWARD

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ANNEXES

ACRONYMS

AFPP	Albania Family Planning Project
BCC	Behavior Change and Communication
COPE	Client Oriented Provide Efficient
CSC	Contraceptive Security Commission
CYP	Couple Year of Protection
E&E	Europe and Eurasia Bureau (USAID)
FP	Family Planning
GOA	Government of Albania
HC	Health Center
HF	Health Financing
HII	Health Insurance Institute
HMIS	Health Management Information System
JSI	John Snow, Inc
LMIS	Logistics Management Information System
MOH	Ministry of Health
MT	Master Trainer
PHC	Primary Health Care
PHRplus	Partners for Health Reform Plus
PROShëndetit	PROHealth
TOT	Training of Trainers
TAPEE	Transparency, Accountability, Prevention, Enforcement and Education
SDP	Service Delivery Point
SO	Strategic Objective
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	Unites States Agency for International Development
USG	United States Government
URC	University Research Corporation
WCR	Women's Consultation Room
WHO	World Health Organization
WWC	Women Wellness Center

EXECUTIVE SUMMARY

At the request of the United States Agency for International Development in Albania (USAID/Albania), a three-person team including Harriett Destler and Nathan Blanchet of Europe and Eurasia Bureau (E&E), and Joyce Holfeld of IT Shows Inc, assessed the mission health strategy and current portfolio. The purpose was aid the mission in developing its next strategy. The team met with officials of USAID, Albanian government, the implementing partners and other donors, and reviewed program activities n three prefectures. Timing of the visit proved fortuitous for three reasons: the mission is preparing its strategy for 2006-2011, the World Bank is designing its next health loan, and the newly-elected Government of Albania (GOA) is laying out its priorities in health.

While the mission has supported health activities for more than a decade, various national events disrupted assistance. For example, support for family planning with John Snow Inc. (JSI) has had two major hiatuses: once in the 1997 due to civil unrest in response to the pyramid schemes, and again during a year in 2003 due to mission reprogramming. In 2003 the mission refocused its strategic objective and narrowed its program. The current $3.4 million annual health budget[1] now supports two projects: one, *PROShëndetit*, in primary health care (PHC) reform with University Research Corporation (URC) and the other in family planning with JSI. Organizational and staffing issues delayed the URC startup almost a year. Along with the slow-down caused by recent Albanian elections, the projects have only been fully-functional for less than twelve months.

This report has three themes: achievements, challenges, and a way forward. Chapter I provides introductory information, including general background information, a brief discussion of the mandate for the appraisal and the methodology used by the team. Chapter II focuses on the current status of the program. Chapter III reviews the strategic framework, achievements and challenges and lays out a way forward. It includes a three-step strategic approach and the team's findings, conclusions and recommendations. Chapter IV briefly summarizes the major conclusions and recommendations. The annexes include supporting data and reference information.

The team believes strongly that USAID's investment in health is critical to the achievement of the entire U.S. Mission's strategic goals, particularly in democracy and economic growth. Albania needs healthy citizens to prosper and grow. Premature adult deaths and excessive morbidity weaken the labor force and break up families. The spread of infectious diseases like avian flu, tuberculosis or HIV/AIDS can slow or halt progress. Present inequities and inadequacies in health delivery divert citizen resources from productive use and bankrupt families. Poorly managed facilities and perceived corruption at all levels within the health sector lessen citizen belief and trust in government. Conversely, health systems provide well-known tools to address corruption and other

[1] This total includes the $1 million in supplemental funding for family planning that the mission received in 2004 and is using in 2004-2006.

social ills, such as trafficking. Fortunately, the current activities and plans of USAID/Albania, the projects, other donors, and most importantly the new Albanian government are very well aligned to advance an agenda in health. Finally, current health outreach activities are mobilizing communities and empowering citizens to advocate for better health care.

The team found that the current USAID program has initiated substantive activities necessary to improve primary health care delivery (the mission's objective) and to support the new government. The new government established in mid-2005 has "pledged to carry out a fundamental reform of the health system" with particular emphasis on PHC and public health, increase allocations for health and curb corruption in the sector. The political will and capital of the new government are essential for success. To succeed in improving health care for Albanians, however, the mission and partners should:

- Develop and adhere to a focused strategic vision with clearly defined end results.
- Invest more in coordinating parallel project and donor activities to ensure realistic expectations; sufficient attention to policy, regulatory and supply considerations; reduce redundancies/fragmentation, and better define USAID's role in that process.
- Raise the level of USG policy dialogue with the GOA to promote the legal, regulatory, financial, and management reforms to support effective PHC delivery and other essential public health activities.
- Assist the government in defining a realistic, evidence-based and affordable set of essential PHC services, and the related provider roles, that meet the needs of Albania's rural, and increasingly urban, population.
- Develop, apply and refine service organization and delivery in a representative sample of health centers and affiliated health posts[2] and monitor client and provider response. Ensure that a critical mass of health centers/posts each deliver a well-defined set of essential integrated PHC services.
- Monitor key critical assumptions to ensure that the program conforms to political, operational and client realities.

Many steps, and the foundation for moving forward, have already been taken or planned. But to make more explicit the direction advocated, the team developed a simple strategic approach. This "three-step approach" emphasizes the need to develop a standard(s) for health centers, implement these cohesively in a subset of representative health centers, and then roll out this program to reach significant numbers of Albanians. The findings and analysis that underlie this approach and specific recommendations as well as the responses to specific questions raised by the mission are discussed in the chapters that follow.

[2] The team is using the term "health center" for any central PHC facility and its affiliates, such as health posts, wellness clinics, that provide or are intended to provide PHC services to a meaningful population

I. INTRODUCTION

Health indicators in Albania lagged within the region before the fall of the country's communist dictatorship in the early 1990's, but they worsened as the clinical and preventive health care delivery system dramatically deteriorated during transition to a more open and competitive political system in the early 1990's.[3] The rise of violent Balkan regional conflicts and domestic political turmoil over the decade compounded declines in the health system that had been brought on by sharp reductions in public sector investment. Despite improvements in the past few years, mortality and morbidity levels in Albania today remain higher than in all but a few countries in the southeastern part of the European region. That said, Albania's main health indicators are surprisingly better than expected based on the country's very low socio-economic indicators and comparatively small financial allocations to the sector. Albania is at-risk, however, due to dramatically changing lifestyle, increased population mobility, and other global health threats. (See Annex B.1 for a summary of economic, demographic and health indicators for Albania, and Annex B.2 and B.3 for a comparative analysis of health status within the region).

Health assessments by USAID and other international agencies over the past decade conclude that extensive legal, regulatory, financial, and programmatic reforms of the health care system are prerequisite to raising health indicators to levels akin to those of neighboring Balkan countries. Most analyses indicate that severe financial constraints make large increases in public sector health investment unlikely, especially in view of limited absorptive capacities due to "inadequate management" of existing public resources. These appraisals generally prescribe or imply a steady increase in overall investment coupled with improved management and organization of services.

The GOA encouraged health sector reforms, beginning with a national health insurance program devised in 1995 and launched in 1996. In 2004, the Council of Ministers approved a ten-year health strategy with PHC as the foundation for health system reforms.[4] The new Government, in the "Government Program, 2005-2010" submitted to the Albanian Parliament in September 2005, pledged to carry out "fundamental reform of the health system at all levels with considerable allocation of public funds."

USAID's current operational strategy under the Strategic Plan 2001-2004, extended through 2006, seeks to support the GOA in efforts to **improve PHC in Albania**. The program encourages better management of health resources with increased cost-effectiveness. The approach aims to acquire understanding of health care financing realities sufficient to help the GOA test more efficient ways to invest in the sector, particularly in PHC. USAID's interventions also promote operational models that increase

[3] These background notes draw directly from the excellent material provided by the mission in the scope of work for the team appraisal.
[4] The Minister of Health who launched these reforms and his Deputy have recently been reappointed by the new government.

capacities to absorb more public finance based on higher quality of, and greater public demand for, primary and preventive health services.

The environment for change is ripe and the potential for large gain is great. The government is fully supportive of improving the health care system. While current investment levels are low, the new government has committed greater resources to the social sectors, particularly the health sector. The World Bank is currently designing a large loan ($10 million) which will support the development and improvement of the health care system in Albania. This loan should come on line in 2007. USAID/Albania has been the major donor in primary health care and a very important player in the policy arena. USAID-financed projects have provided much of the analytic material for GOA decision making in health and have developed and replicated working models for the improvement of the country's PHC delivery system.

USAID/Albania is also at a crucial juncture as it prepares its new program strategy for the coming years. The USAID program planning is particularly important now as it coincides with the development of plans for the new government, and the planning cycles of the World Bank, World Health Organization (WHO) and other donors. USAID/Albania commissioned this team to conduct a mid-term appraisal to review health program achievements to date, assess the impact of the current programs, and to develop practical recommendations for performance improvement and future mission strategic planning.

The specific objectives of the appraisal were to:

- Review the Mission's current Strategic Objective (SO) 3.2—Health Strategic Framework;
- Examine progress to date of the two SO3.2 contracts, specifically:
  - Improving Primary Health Care (*PROShëndetit, meaning ProHealth)*, 2003-2006, and
  - Albania Family Planning Project (AFPP), 2004-2006;
- Advise on the extension and/or adjustments to URC/*PROShëndetit* and any adjustments to JSI/AFPP for the concluding months of this activity;[5]
- Prepare a report that develops practical recommendations for program direction and mission strategic visioning.

The team used several major questions to guide the appraisal, specifically:

- Is USAID's health strategy right for Albania?
- Are main USAID-financed projects (*PROShëndetit* and AFPP) optimally using their resources to reach agreed upon Goals?
- Are the health interventions and activities having the right impact?
- Is anything missing in current program design that should be considered?
- Assuming no increase in funding, should strategy and program directions, priorities and/or any activities be modified in the near or medium term?

[5] The team is making its recommendations on these points in a separate memorandum to USAID.

The appraisal team worked in Albania, September 18 – October 8, 2005. The team collected, reviewed and analyzed existing literature on the situation in Albania,[6] current program[7] activities, and relevant program and technical reports. The members of the team interviewed Mission staff, project and implementation personnel, host government officials, other donors and stakeholders. The team conducted field visits to three prefectures: Lezhë, Berat, and Korçë to:

- meet with government authorities and community leaders, service providers and managers;
- observe service delivery and meet with clients and beneficiaries; and
- see first-hand existing facilities and service delivery points, including local hospitals, health centers, health posts, commune outreach, and local pharmacies.

At mid-point in the visit the team held meetings with mission and program leadership and with stakeholders to solicit input for final recommendations. Finally, based on all information, the team developed this report with findings, conclusions and recommendations.

A listing all recommendations with designated responsible parties is included in Annex A. The full scope of work of the appraisal is included as Annex F.1; a bibliography of key documents reviewed is included in Annex F.2 and persons interviewed are listed in Annex F.3.

[6] Again the team would like to acknowledge the excellent materials provided both by USAID and project staffs.

[7] To simplify discussion, the team has combined the "projects" and when discussing both projects uses the term "program." When these diverge and specific mandates, accomplishments, activities and/or challenges are "project specific," these are discussed separately with the relevant project cited. Both Contractors deserve high praise for their successful ability to coordinate and work together to implement project activities around the USAID strategic framework.

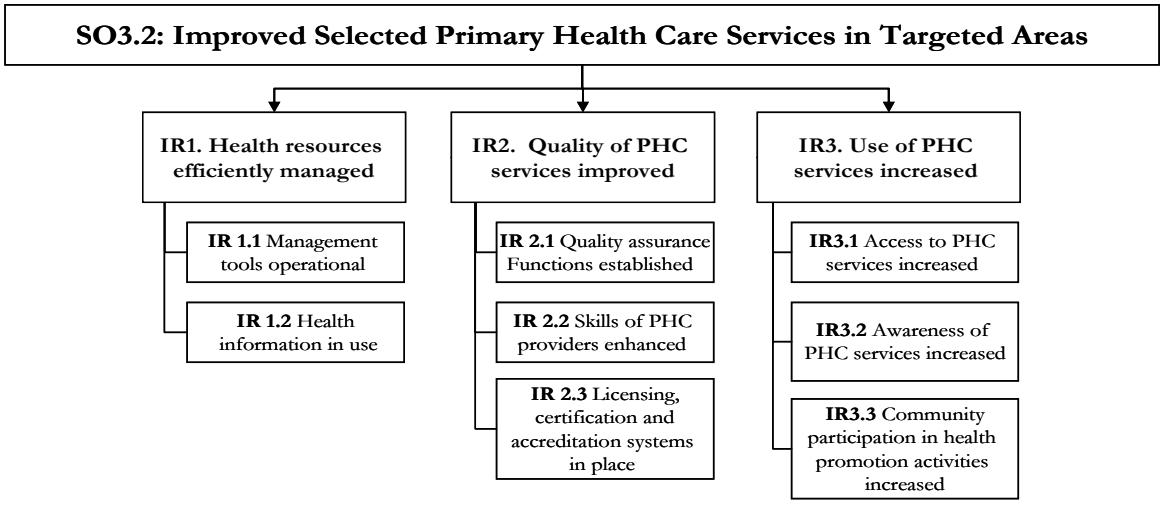
II. USAID'S CURRENT HEALTH STRATEGY AND PORTFOLIO

A. HEALTH STRATEGIC FRAMEWORK FOR USAID/ALBANIA

USAID/Albania's Country Strategic Plan includes a strategic objective for the health sector. Several sector assessments had recommended that to improve or even to maintain good health indicators in Albania, U.S. assistance should focus on strengthening the PHC system and improving its long-term sustainability. As a result, the Mission developed the strategic framework for the period 2000-2006 as noted in the figure below:

Figure 1:

USAID/Albania
Results Framework for SO 3.2



B. PAST USAID PROJECT INTERVENTIONS IN THE HEALTH SECTOR

In the mid-1990s, USAID initiated social transition activities mostly though centrally-funded projects. In 2000, USAID/Albania initiated bilateral activities, included health in its strategy and provided direct support to the development of the Albanian health system through a number of projects. In 2001, the PHRplus project initiated work to help the GOA improve the delivery of PHC for later replication. It tested a pilot design in Berat to improve PHC services in two urban and two rural health centers. The project worked for two and a half years with local and national stakeholders to develop tools and systems in areas of service delivery, quality of care, health information systems, and financial reforms linked to performance of primary care providers. The project assisted local authorities in Berat, the MOH, and the Health Insurance Institute (HII) in implementing these reforms in other PHC facilities in the Berat and Kuçova districts. A number of significant studies

documenting the program were completed during the span of the PHRplus project, including: 1) *Primary Health Care Reform: Baseline Survey of Health Service Utilization, Expenditures, and Quality*, 2) *Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis*, and 3) *A Pilot Project to Provide Evidence for Health Policy*. PHRplus completed its activities in March 2003. An on-going project with the URC and partners noted below has successfully incorporated and built upon these significant interventions.

USAID/Albania also funded John Snow Inc to provide, "Technical Assistance to Improve Access to Quality Reproductive Health Services for Albanian Women." This project improved the system for providing and maintaining a reliable supply of contraceptive commodities; increased the amount and quality of information provided to clients; and strengthened the competency of health providers to offer a wider range of the reproductive health services. By the time the JSI project ended in 2003, it had trained more than 650 health care professionals in 244 service delivery sites in 20 districts significantly increasing family planning services in health centers, maternities and women's consulting rooms (WCR). Also, a National Contraceptive Security Commission (CSC) was established under the project. The project, with MOH and UNFPA, developed and continues to operate a logistics management information system (LMIS) nationwide to provide contraceptives throughout the nation. This project ended in 2003. After a hiatus of approximately one year and through special "supplemental funding," activities were resumed to complete nationwide expansion of the family planning program.

C. Current Project Activities in Albania

In 2003, USAID/Albania contracted URC with partners Bearing Point and the American Academy of Family Physicians to implement its umbrella contract ***"Improving Primary Health Care in Albania"*** (named *PROShëndetit* meaning ProHealth). The contract covers the period 2004-2006, with an option to extend one or two years.

Objectives
PRO Shëndetit Project

Improve PHC Services in Targeted Areas:

- Assist GOA to manage health resources more efficiently;
- Assist MOH to improve the quality of services
- Increase the utilization of PHC services.

PROShëndetit provides technical support to strengthen program management and improve the delivery of an integrated basic package of essential services within the primary health care system. The package includes disease detection and prevention (including chronic disease prevention and management), maternal health, child health, reproductive health/family planning, tuberculosis, and HIV/AIDS. Integration is to provide increased access to services by bringing services closer to consumers; providing one-stop shopping for basic PHC services; increasing continuity of care; improving the performance of service providers; reducing missed opportunities; and, importantly, increasing demand for services. The project also has a strong health promotion component which works to increase general awareness of health issues and PHC benefits. In addition, the project encourages people within communities to become more aware of health options and their

own capabilities to influence good health—in essence, to become active citizens and to take personal responsible for health care.

PROShëndetit also supports GOA's efforts to reform the way primary health care is financed in Albania. The financing reform objectives are to consolidate public funds for PHC into a "single source payer" and to introduce managerial autonomy and performance-based contracting for primary care providers. These reforms are deemed vital to making lasting improvements in the transparency, accountability, efficiency, and quality of health services at the primary care level. Finally, *PROShëndetit* is technically aiding GOA in rolling out an electronic health management information system (HMIS), a vital tool for monitoring and improving resource flows, provider performance, and client use.

Objectives
Albania Family Planning Project
Improve FP Services within PHC

- Complete family planning training the with country's remaining 16 (out of 36) districts not covered by earlier efforts.
- Develop an awareness campaign to increase and promote the use of modern family planning methods.
- Assist the MOH to achieve and maintain contraceptive security.

In September, 2004, with supplemental family planning funds, USAID awarded a Task Order to JSI with Manoff Group under the Maternal and Child Health Technical Assistance and Support Contract to implement the two-year **Albania Family Planning Project in Albania, 2004-2006.**

AFPP operates within the national PHC Framework established by the MOH with the objective to improve the family planning component of primary health care. The project focuses on the 16 districts (out of 36 country-wide) where family planning services had not been introduced by previous projects. AFPP makes full use of the curriculum, cue cards, and trainers previously developed by an earlier USAID-supported JSI project. The project increases MOH training capacity by development of master trainers (MT) capable of district-level FP training. AFPP uses a combination of mass media, print materials and community mobilization to increase awareness of the availability of family planning methods and services, to motivate people to seek those services and to use safe, reliable family planning methods to achieve their goals for timing and limiting pregnancies. AFPP also supports the MOH LMIS to ensure an uninterrupted supply of contraceptives to all service delivery points (SDP), and to support the Ministry-led CSC which will maintain an uninterrupted supply of contraceptives for the long-run.

More complete details on each of the current USAID contracts are included in Annex D: URC and partners in Annex D.1, and JSI and partner in Annex D.2.

D. FUNDING FOR USAID/ALBANIA HEALTH PROGRAMS

USAID/Albania reinstituted funding for health in FY 2000, and since, has continued funding as noted in the Table 1 below. Since 2001, health funding has been 11-14% of the Mission's operating year budget (OYB). These funds were primarily allocated to the PROShëndetit Project, which has a life-of-project level of $6,502,646 for the period 8/12/2003 to 8/30/2006. Annual health funding will probably be straight-lined for FY 06.

Table 1: USAID/Albania: Health Funding
(in thousands)

	FY00	FY 01	FY02	FY 03	FY 04	FY 05
Health	$950	$4,125	$3,775	$3,000	$2,450	$2,966
USAID Total OYB	25,278	29,548	29,040	21,133	21,603	21,766
Health as % of OYB	4%	14%	13%	14%	11%	14%

In **addition** to the mission's regular funds, USAID/Albania received, in 2004, $1.0 million of one-time, no-year supplemental funding from the reprogramming of family planning money from the Child Survival and Health Account. These funds were allocated to the AFPP for the two-year period 10/30/04 to 9/30/06. Although Albania was considered a priority country for supplemental funding for family planning in FY 2005, USAID/Albania did not request any of these funds (and therefore did not receive any additional funding).

Combined, USAID provides around $3.26 million per year to implement the mission's health objective. This sum represents approximately 23% of the annual donation of all external donor assistance in PHC, thus, making USAID the largest single bilateral donor for primary health care in Albania.

III. FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter provides the team's overall and detailed findings, conclusions and recommendations. As well, the team offers responses to the specific questions raised by the mission in the scope of work. The chapter has been divided into two main sections: A) Strategic Relevance, Focus and Coherence, and B) Translating Theory into Practice: Implementation and Impact. In addition, given the interest in and importance of health care financing, the team has included as third section, Special Case-Health Care Financing which addresses specific questions raised by the mission on this subject.

The discussion in this chapter needs to be prefaced by an articulation of the team's major assumptions:

- USAID assistance in health supports USG goals in Albania.
- USAID-financed health assistance to GOA has made important contributions this past year and should be continued. USAID and project leadership and teams deserve congratulations for work well done.
- The time is right for the mission to reaffirm its commitment to health.
- As USAID/Albania looks to the future in its next strategy, it should set sights higher, focus its strategic vision and define clearer end results.
- This builds upon recent gains in GOA commitment and can be done within current and projected resource levels.

A. OVERALL STRATEGIC RELEVANCE, FOCUS, AND COHERENCE

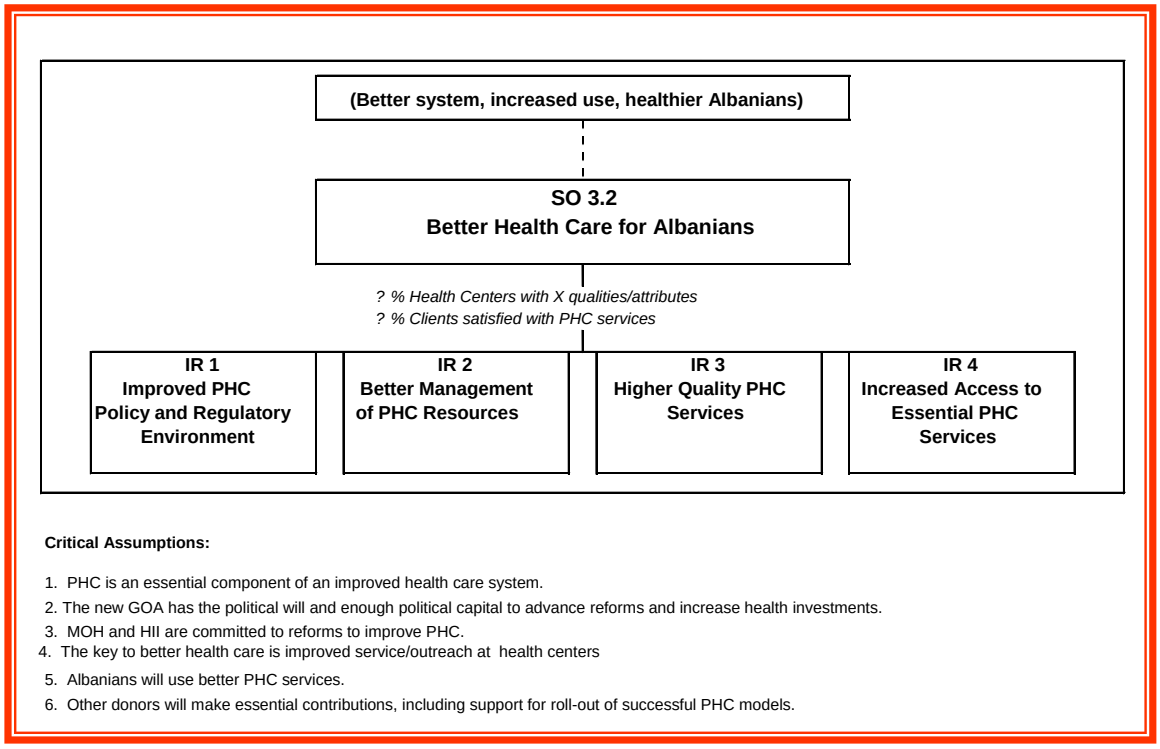
1. Strategic Objective

In 2000, USAID/Albania narrowed its strategic objective in health to define a more modest set of achievements that would be within its manageable interest and planned health allocations. The objective was changed from "Improved Sustainability of Social Benefits and Services" to "Improved Selected Primary Health Care Services in Targeted Sites."[8] In November 2004, a strategic revalidation report commissioned by the Mission endorsed this objective level and cited program issues identified in an April 2003 health sector assessment.

A year later, this health appraisal team is recommending that the mission raise its sights and consider a new strategic objective, "Better Health Care for Albanians" for the strategy it is beginning now. A preliminary results framework with this proposed objective and the critical assumptions underlying it are shown in Figure 2.

[8] USAID Strategic Framework, SO.3, see Figure 1, page 4.

Figure 2: Suggested Refinements to SO 3.2 Results Framework



The team believes that the proposed modification of the present strategy is right for the mission and for Albania. This conclusion is based on:

- The **gains of the past year** in strengthening health systems and provider skills and knowledge. This progress is discussed in the section that follows on program implementation and impact.
- The **increased donor consensus** on what needs to be done.[9] The World Bank, the other major donor in PHC, is preparing a major new health loan whose design builds upon past and current USAID assistance.
- **New opportunities to work in health with the new government**. The new government has pledged to "carry out a fundamental reform of the health system" with particular emphasis on PHC and the public health sector, increase allocations for health and curb corruption in the health sector.[10] The initial appointments in the health sector include individuals with strong credentials and commitment to health reform and PHC.
- The **opportunity that the new mission strategic planning process provides**.

[9] "Policy Notes for the Government of Albania (10 Health Sector Reforms)" See Annex C.2
[10] The Government of Albania Program 2005-2010 as presented to Parliament on September 9, 2005

At current and projected levels, USAID has the resources to make a difference in a country of this size and population. But to make a difference and enable the GOA to provide "Better Health Care for Albanians," the mission must paradoxically raise its sights and narrow its focus. To do that, it must concentrate program resources on improving a set of essential primary health care service delivery and management systems at a significant number of health centers or other major PHC delivery sites. These facilities need to be able to provide an integrated, well-defined and limited package of primary health care services and have all or most of the "pieces" together to manage and deliver affordable, quality primary care services and meet client needs. The pieces include: not only a defined set of essential PHC services, but empowered providers, equipped facilities and informed clients.

Currently, many Albanians bypass health centers because they believe that these facilities provide little or nothing in health care. In many cases, these citizens are right. This leads to low use of PHC facilities and subsequently low work loads for staff. A recent analysis noted that "on average a primary care doctor sees only about eight patients a day"[11]. The system has a number of checks and balances and internal inconsistencies which limit what even the most dedicated health provider can deliver.

Implicit in this suggested strategy are several critical assumptions based on global health experience and the team's briefings in Albania. These are that:

- Primary health care is an essential component of an improved health care system.
- The key to better PHC is improved service delivery/outreach at the health centers and their affiliated health posts.
- Albanians will use health centers if they provide better PHC services.

These and other critical assumptions discussed below must be monitored as the new strategy is rolled-out, as results are defined, and as program performance targets are set.

Recommendation

- *Set a health objective for the new USAID strategy statement along the lines of "Better Health Care for Albanians" (USAID)*

2. Supporting Actions

The suggested new results framework (Figure 2) show graphically how the supporting results and program activities contribute to improved primary health care delivery and ultimately provide better health care. These point especially to the importance of an improved legal and regulatory environment as essential to the achievement of all results. Changing the legal and regulatory basis on which primary health care services are delivered, managed and supported is a large task. It requires action at all levels of the Albanian publicly-financed health system and concerted action, close cooperation and coordination among various government agencies and departments such as the Council of

[11] Policy Notes for the Government. Note that this contrasts with a workload of 30 patients a day in Denmark.

Ministers, MOH and HII. The U.S. needs to use the considerable credibility and technical resources it has in policy dialogue, analysis and technical assistance to help the government make the decisions it needs to create robust sustainable, primary health care facilities, empower providers and enable clients to benefit from these changes. This is why there is such emphasis on the first new contributing result, an improved health policy and regulatory environment. It is also why the critical assumptions about the new government and other donor support are so important. These are:

- The new government has the political will and political capital to advance reforms and increase health investments.
- GOA/MOH and HII are committed to reforms to improve PHC and to reconciling management, resource allocation, standards and reporting where necessary.
- Other donors will make essential contributions including support for the rollout of successful PHC models.

For PHC to be improved, the government must make some hard decisions and take a number of critical actions. These vary considerably. One area that it is both very important and urgent is **determining the basic package of services** that need to be delivered at health centers and affiliated health posts or other large PHC facilities. The list needs to include essential and affordable services. There may need to be more than one basic package to match the differing needs of, for example, rural versus urban health centers. Among the PHC services which the team felt were important to include are: prevention, detection and management of major non-communicable diseases; pre-natal care, family planning, child vaccination, prevention and treatment of minor injuries as well as prevention and awareness of other growing health risks such as HIV/AIDS and changing life styles.

It may be possible to integrate or agree upon some of these services faster than others because of the current division of responsibilities among departments in the GOA. However, it is critical that the GOA carefully identify at least a preliminary basic PHC package(s) that are priority. Then, a) provider roles can be defined and authorized, b) standard treatment or counseling protocols can be developed, with supporting training and supervisory services c), systems for ensuring that health centers have the supplies needed to provide can be developed; and e) provider/client materials can be designed and disseminated. Exactly how this is done may require allowances for local realities, responsiveness to GOA's devolution and decentralization to local government authorities, and will certainly be one of the key policy issues to be explored.

Similarly, the MOH and HII have to agree on reimbursement for this basic package and develop the requisite health information and financial systems. Along with deciding what PHC services will be supported at health centers, the GOA needs to decide what will not be publicly-financed or provided at the health center level. In developing standards and the regulatory framework, the GOA also needs to consider the private sector and how to regulate but not hamstring this sector and independent primary care physicians. There are a number of very difficult policy decisions that the GOA will need to make over time about expectations for care and the rationalization of facilities and staff. The health information

and cost data developed under the current program can help the government identify, justify and strategically implement these decisions.

The GOA needs to increase its overall allocation for health, which is one of the lowest in the Europe and Eurasia (E&E) region. In particular, it needs to increase resource allocations for health promotion and other public health intervention, surveillance and improved health information systems. The country is ill-prepared for the changing patterns of disease associated with changes in life style and new health risk factors associated with an increasingly mobile population. These and a number of other policy, program allocation and regulatory actions are included in the donor policy notes.

Recommendations

- *Take a more active leadership role with other donors and support the development of a common agenda for policy dialogue and donor assistance (USAID).*

- *Maintain a U.S. health policy agenda and use the full U.S. presence for policy dialogue on health with the new government (US Ambassador, USAID Director, other USAID staff and program staff).*

3. Relevance to USG Strategic Goals

Relevance to U.S. Mission in Albania Strategic Goals. This proposed objective and the related activities contribute to the achievement of at least three of U.S. Mission to Albania‘s 2007 mission performance plan goals. It supports the performance goal in democracy and human rights by empowering citizens to act through commune health reform committees and by addressing corruption through health system reforms which increase transparency and accountability. It is essential for economic growth to protect the labor force and conserve family resources. And finally, by supporting the GOA’s investment in the health of its population, it moves Albania closer to European Union membership and Millennium Challenge eligibility and contributes to the performance goal of close ties with allies and friends.

USAID Strategy, Comparative Advantage and E&E Bureau Framework. This proposed strategy also reflects current best practice in health, USAID policy, and the E&E Bureau’s strategic framework. It includes areas of health assistance where USAID has a comparative advantage, e.g. health systems, primary health care and training and outreach. It is consistent with USAID policy and the “Foreign AID in the National Interest” report which states “fundamental to this (economic) growth is improving people’s health and education…more resources will be available to invest in economic endeavors. But for that to happen, workers must be productive—and to be productive, they must be healthy. Diseases that cause illness and premature death must be identified, prevented, and managed including future diseases... There needs to be “more collaboration among missions, sectors and donors”.

The proposal is in accord with the September 2005 USAID E&E Bureau Strategic Framework. "Health is a concern for all E&E missions…it is essential that USAID's health approaches be affordable, feasible and the greatest impact possible…successful approaches promote high level political commitment and individual responsibility, strengthen primary health care and improve health care management and systems."

4. The Way Forward – A Strategic Approach

The appraisal **team was impressed with what it saw**. While the team suggests some changes in USAID's strategy and implementation refinements, the program [12] as it now stands is generally on the right track. There are talented and committed staff working closely with the GOA to develop and implement interventions that strengthen systems and deliver services that will ultimately provide better health care for Albanians. The new government, in the "Government Program- 2005-2010," articulated a commitment to the reform of the health sector, and pledged resources to these reforms.

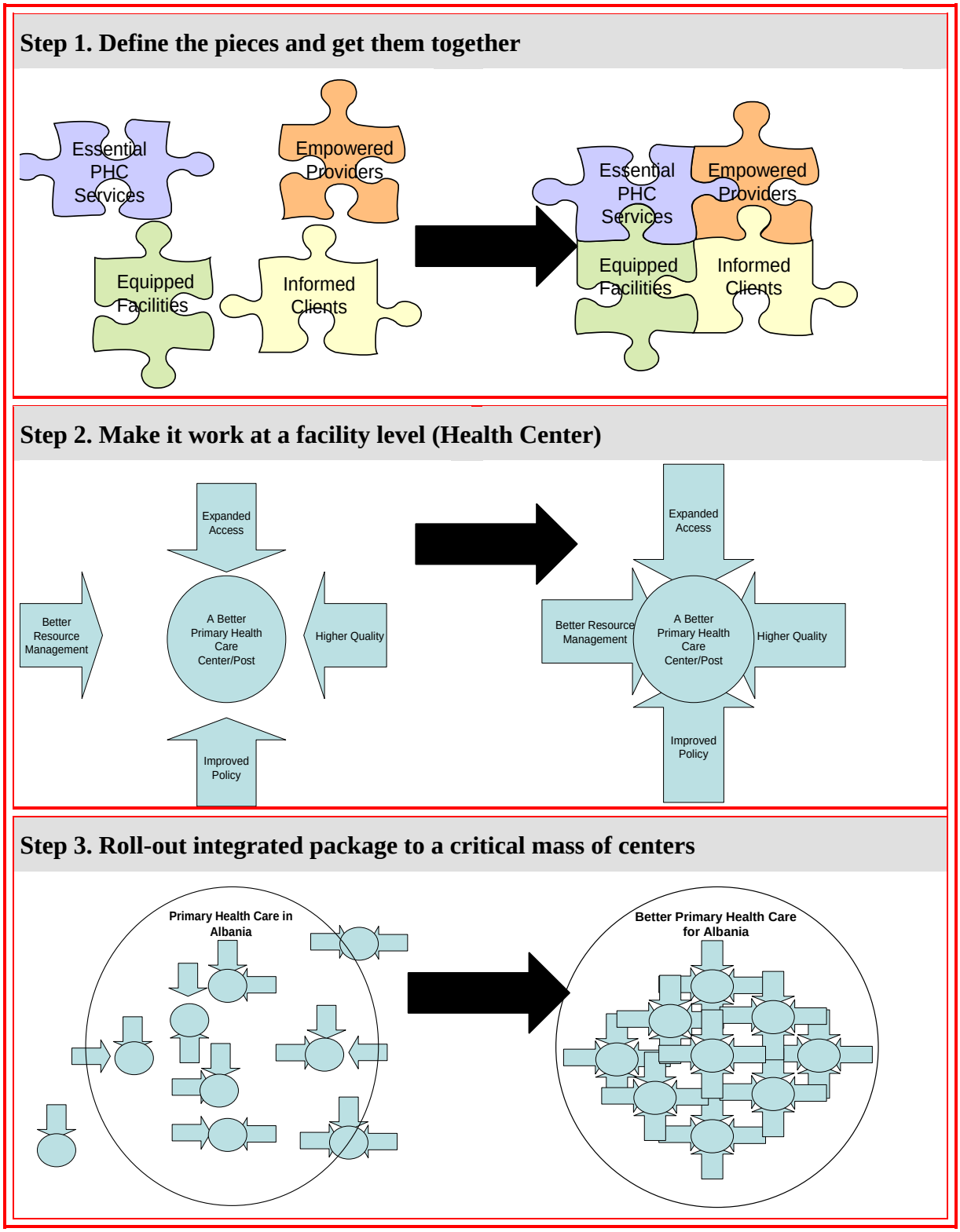
But, Albania's current PHC care system is still too often fragmented, redundant, and guided by unaffordable expectations. There are currently over 2,500 public outpatient facilities. Health centers and health posts rarely offer an integrated package of PHC services, even in pilot areas where USAID has been operating for some time. Some offer monitoring of chronic conditions for mostly adult patients, for example, but do not provide simple immunizations or pre-natal care for pregnant women. Others may adequately cater to the needs of pregnant women and children, but do not have the capacity to monitor blood sugar levels of diabetic patients. This fragmentation causes inefficiency and low productivity. It also has Albanians voting with their feet and bypassing primary health care centers. The current state of the PHC system suggests, not surprisingly, that there is much to be done by the GOA, local communities, USAID and other donors.

This led the team to develop a strategic approach to respond to the fragmentation, build upon the excellent program work in improving health systems and information, provider, skills and outreach, take advantage of the improved GOA and donor situation and move forward in a pragmatic way to implement the proposed new USAID strategy and work with host country and donor partners to provide better health care for Albania. The strategic approach is broken into the three steps schematically shown in Figure 3 on the following page:

- **Step 1**: Define the essential PHC "pieces and put them together.
- **Step 2**: Implement this package of services and the supporting systems at health centers, and
- **Step 3:** Roll-out the package of integrated PHC services/systems to a critical mass of health centers to reach a significant number of Albanians.

[12] Reminder: To simplify discussion, the team has combined the "projects" and when discussing both uses the term "program." Both contractors deserve high praise for their successful ability to coordinate and work together to implement project activities around the USAID strategic framework. When these diverge and specific mandates, accomplishments, activities and challenges are 'project specific," these are discussed separately with the relevant project cited.

Figure 3: Three-Step Approach for Achieving Better Health Care for Albania



Defining and putting the pieces together. The current program teams, and predecessor project teams, have already designed and initiated many of the critical actions and activities needed to improve PHC in health centers[13] which serve or are able to serve significant[14] populations. Not surprisingly, the design and implementation of various activities have tended to move ahead at different rates. This results in a scattering of activities across various health centers and other facilities – with some having health information systems, others having providers trained in a particular specialty and still others have outreach and health promotion activities.

The team feels strongly that this is a critical time for USAID, the contractor teams, the GOA and other donors to step back and look systematically at the barriers to better care and greater use of primary health care. For example, when asked, clients say they bypass health centers because these offer little value, few services, poor quality, etc. The client may be directed to visit several facilities to get complete service for a simple health problem. In some cases, even the most motivated of providers cannot deliver an essential service because he does not have the authority, is not trained and/or lacks a basic commodity, supply or drug to handle the problem. Resolving these types of barriers require looking at the whole or the major pieces in puzzle together. This requires developing a model with a defined basic package(s)[15] of essential services which a PHC center[16] should provide *and* the supporting authorities, materials, training and management systems required for these services to be provided responsibly. Step 1 shows four critical elements or pieces of the puzzle:

- A defined set of essential PHC services,
- An empowered provider,
- An equipped facility, and
- Informed clients.

Over time, the elements will certainly evolve but what is important now is reaching agreement on a feasible, affordable set of services and the minimum required to provide these in a manner useful to clients. Also, there may need to be more than one model and more than one package of basic PHC services reflecting the nature, size and location (e.g., rural, urban, and peri-urban) of the client population. Providing this minimum or the bare essentials will require cooperation and coordination among USAID, other donors, the GOA and local communities.

Putting together the puzzle will also require determining the essential elements within each piece and that they are locally appropriate. For example, essential PHC services should include some combination of prevention (vaccination, family planning, prenatal care health education, etc) as well as basic diagnostic and treatment services. For a provider to be

[13] Reminder: the term "health center" is used as shorthand to refer to any central PHC facility and its affiliates that provides or is intended to provide PHC services to a sizeable population.
[14] More than once, the team has used less than precise phrases such as *significant number, critical mass,* or *meaningful sample*. These are terms that need to be better defined and quantified in the Albanian context by those who know Albania better than the team.
[15] There may be more than one model and more than one package of basic PHC services reflecting the nature, size and location, e.g. rural, urban, and peri-urban of the client population.

empowered, he/she must be authorized and trained/certified to provide the service, have a protocol/standard against which to practice and have a reporting system which reimburses him/her for performance. Similarly, a facility needs to have basic amenities like water and light, drugs and other essential supplies and certain basic equipment. The clients need information on where to go for services and how the get them. In each case, the emphasis has to be on the essential and the deliverable not the ideal.

Making it work at a facility level (health center). Once a basic package has been defined, the challenge will be to get that package(s) of basic services functional at a representative set of health centers, monitor provider service and client response and identify and remove any major remaining impediments. Again and again, the team saw the eagerness with which providers used the program approaches (e.g., COPE, community outreach,) and materials (e.g., treatment protocols, and family planning cue cards). One of Albania's real strengths is the motivation and dedication of its PHC providers but often the system lets them down.

Step 2 shows four program elements needed to enable a health center to deliver better primary health care or create workable models. These are:

- Supportive policies and regulations,
- Adequate health management systems,
- Quality standards and training, and
- Access (set of essential integrated services and client knowledge).

Differences in population, resources and geography suggest that there will not be a single model that fits all of Albania. Implementation will have to be adapted to the local setting. The program has generated a lot of valuable information now on which to make decisions about major models. Adapting these models over time may require further analysis of patterns of use or non-use of PHC (Where, for example, do women get pre-natal care), of need (Are the poor less served? Do urban populations really have access to PHC?), and, of course, the changing patterns of habitation and behavior (Where do the people live? Will they use the services?).

Rolling out an integrated package to a critical mass. Once the essential pieces have been identified and working models developed and tested, the final and most important step is to roll out an integrated package of services to a critical mass of health centers which serve significant numbers of people. The pace of the first two steps will determine how fast and how many health centers should be strengthened. Locally appropriate political, programmatic and population factors should determine which and where health centers should be strengthened., the team suggests various criteria for the selection of centers, It is, of course, possible to have a national impact without covering all centers or even all prefectures.

And, finally the team needs to add one cautionary note. It is very important to concentrate most of the program resources in order to develop over time a significant number of primary health care facilities which provide affordable, acceptable, essential services that citizen's value and use. But, there may also be occasions where part of one activity such

as, for example, a preliminary use of part of the encounter form system needs to rolled out differently or somewhat in advance of the other activities to provide information for critical policy or program decisions. Such exceptions need to be carefully thought out and agreed upon but the rule of reasonableness must always prevail.

B. TRANSLATING THEORY TO PRACTICE: PROGRAM IMPLEMENTATION AND IMPACT

The purpose of this section is to review the achievements to date, assess the accomplishments though examples, and to link what is currently happening on the ground to the proposed strategic approach described in the previous section. While the team suggests some changes and refinements in strategy and implementation, the general assessment is that the program [17] is on the right track. There is committed staff working closely with the GOA and the MOH to develop and implement interventions in target areas. Systems are being strengthened to deliver services that will ultimately provide better health care for Albanians. Surveys in the targeted areas are beginning to show that client populations are using more and appreciate the improved PHC services. An important development is that the newly-elected government has made a strong commitment to the reform of the health sector and has pledged resources for these reforms.

1. Pushing Off the Starting Block—Highlights of Program Achievements to Date

The program has advanced. Both projects have a sound base for program action. Both built upon developments of the past: *PROShëndetit* has used the PHRplus' pilot efforts in Berat and Koçovë; AFPP has extended the reach of John Snow's earlier investments. That being said, the program had had a slow start—*PROShëndetit* had a slow organizational start-up and lost much of its first year of implementation. AFPP had to catch-up after a year's *hiatus* in funding. Both projects experienced "slow downs" for the few months leading up to the election. Even so, since September 2004, program activities have progressed and important achievements have been made. The two projects have fully documented progress in their respective annual and quarterly reports and which are summarized in Annex D.

Importantly, each project conducted significant strategic planning as evidenced by the development and submission of life-of-project strategic and operational work plans. Both projects concurrently conducted management and organizational activities: hired staff, set up offices, established management and operational policies and procedures, and conducted team building. Both projects are located on the same compound which has facilitated coordination and communication. *PROShëndetit* and AFPP have worked together on the development of relationships and, where appropriate, have either coordinated activities or implemented them jointly.

[17] Reminder: To simplify discussion, the team has combined the "projects" and when discussing both, uses the term "program". When these diverge and specific mandates, accomplishments, activities and challenges are 'project specific", these are discussed separately with the relevant project cited.

The projects have worked closely with the government in designing and implementing program activities. In fact, activities are implemented by and through the MOH or other host government or partner institutions (e.g., HII and local governments) and the MOH and institutions appear to own the project activities. For example: all trainers and facilitators are MOH staff. All activities within districts are conducted and monitored by health authorities at the district level. A specific request came from the Minister of Health for project assistance to introduce the new health information system into designated MOH service delivery points (SDP). The MOH Contraceptive Security Commission is recognized legally and is accepted as the policy authority for contraceptive security. A Behavior Change and Communication (BBC) Team is composed of MOH central and local offices, and a BBC strategy was developed through joint participation.

The following table highlights significant programmatic achievements for each of the USAID-financed projects.

Table 2: Highlights of Program Achievements by Immediate Results

PROShëndetit	**AFFP**
Health Resources Efficiently Managed	
--The new health management information system is operational at 325 service delivery points, including one complete prefecture and pilot sites in four additional prefectures.	--In the expansion of FP service, at the end of the first year project 96 new SDPs for the project area (50% of AFPP target) or 341 national SDPs;(83% of national SDPs) began providing quality FP service and are now part of LMIS.
--A decree has been drafted for the Council of Ministers to grant permission to the MOH and HII to begin implementing a single-source payer, health financing system of PHC in Berat. Implementation of the new system will bring transparency to financing of primary health care.	--The percentage of SDPs reporting LMIS data for the last quarter (April – June 2005) is: - For 5 intervened districts 97% - For 16 project districts 94% - For all SDPs in Albania 81% --Even though still high, the stock out over the project period has declined.
Quality of PHC Services Improved	
--A quality improvement program at service delivery sites has been established at 61 health centers	--The training curricula and provider cue cards have been updated and revised and the MOH has approved the FP curriculum as the national training curriculum. A cadre of 5 master trainers was developed and new FP trainers were trained to provide national FP training capability. A well planned schedule provided the basis for conducting FP training in the project area.
--A continuing medical education program for nurses and midwives, taught by district level MOH staff, has conducted sessions with for nurses and midwives	--District training programs for general practitioners, Ob/Gyn and nurse/midwives have been established using the Training of Trainers (ToT) and Master Trainers produced from AFPP (ToT and MT are all MOH officials).
--A training program for general practitioners,	--Quality FP service are integrated in all SDPs ,WCR,

consisting of 30 modules, has been established using physicians at prefecture level as trainers: the first TOT to produce trainers has been conducted with 14 physicians.	Maternities, and Health Centers (HC) of 6 new districts (out of 16 project target). All these SDP are recognized through MOH FP logo and now have adequately trained providers with FP curricula and are supplied with FP commodities.
--A system for auditing the clinical performance of physicians has been established in one prefecture and will be established in others as physicians complete the 30 module program.	--At the end of the first year project, 50% of WCRs, 55% of HC and 37% of Maternities of the project area are offering now quality FP service. --For the targeted providers, 64 % of medical doctors and 60% of the nurses/midwives are trained using the national FP curricula. --A system for conducting follow-up visits utilizing integrated M&E tools has been developed and site visits are being conducted in the 5 districts trained in year 1 --The same progress will be followed during the second year of project in the remaining districts.
Increased Use of PHC Services	
--A community-based health promotion program has been established in 30 communes to educate women and men about and to promote primary health care.	--There has been an increase in utilization of SDPs reflected from population access on FP service. This access is shown through an 20% increase of total FP visits for the last quarter compare with the quarterly average of 2004.
--There has been an increase in utilization of services in the five initial-focus prefectures. The service utilization rate (number of contacts with a service delivery site per 100 population) went from 66 in 2004 to 248 in 2005 – part of the increase due to capturing more information through the new HMIS and part due to increase in use of services.	--There is a doubling of FP counseling for the project area: the 2004 AFPP baseline is 686 while the last quarter figure of counseling visits has reached 1440.
--There is strong evidence that the use of modern contraceptives has increased. A national survey showed 8 percent of married women used modern contraception in 2002 and a three prefecture survey (Shkoder, Lezhe, and Korce) in August 2005 shows 15 percent of married women currently using modern contraceptives.	--Through the first quarters of the AFPP project life, there has been a significant increase (14%) in couple years of protection (CYP) in the 5 intervened districts compared those districts with no interventions..
--For the same two surveys mentioned above, the percent of rural women having a minimum of three prenatal checks went from 28 in 2002 to 57 percent in 2005.	--Of 203 nurse and midwives trained from AFPP, 48 were community midwives increasing community outreach for FP information and service and strengthening the link between the SDP and the community.

In sum, the program has made major strides. The development of new management information systems (LMIS/HMIS) is especially notable. The program adapted Client

Oriented Provider Efficiency (COPE), a site based quality improvement program and has also linked community-based health promotion and outreach to the facility-based services. The program enhanced provider capacity, through development of trainers and the training of practitioners, nurses, midwives and health educators. The program initiated a continuing medical education (CME) to provide updates on topics selected by a CME board in pilot districts. The program developed and disseminated tools such as the cue cards, treatment protocols, patient materials, updated curricula and resource materials to support the delivery of quality services and these tools are understood to be widely in place at most program sites. The efforts with on contraceptive security appear to have cut down the number of stock-outs of supplies.

The team's assessment of program success and impact continue below. The comments mention, but do not focus on, all the good happenings. Rather, the team's conclusions and recommendations are directed to constructive advice which link future program activities to the proposed strategic objective and the strategic approach. These refinements also align with the new government's plans.

2. Results Measurement

USAID's (and consequently the projects') current performance monitoring system makes assessing and communicating the results or impact difficult for certain areas. The team found two types of problems with the current system: 1) "standard" indicators that measure a different result than the one stated and 2) definitions of "custom" indicators that are either poorly matched to the stated result or that set the bar too low. The following Table 3 offers a few examples of these problems. The bottom-line is that these weaknesses in performance monitoring hinder the Mission's and the projects' ability to measure results/impact objectively in order to fix problems or share successes.

Table 3: Result Framework-Measurements

Activity	Current Result	Current Indicator	Indicator Definition	What's the Problem?
PRO Shëndetit	(SO) Improved Selected Health Care Services in Target Areas	Use of modern methods of contraception (married women)	(Standard)	This indicator measures a higher level result (use) than the intended result (improved services).
PRO Shëndetit	(SO) Improved Selected Health Care Services in Target Areas	Percent of service delivery points providing integrated PHC	"Integrated PHC" refers to any SDP where 1) updates and basic skill improvement have taken place; 2) HMIS is in place; 3) QI is being undertaken; *or* 4) clinical improvement for GPRO Shëndetit is being taught	The definition here is doubly problematic—it is poorly matched to the concept/result of "integrated" care, and it sets a very low bar. It is poorly matched because "integration" refers to multiple health services being offered under one roof, not the various quality standards this definition lists. Even if the definition were right, the bar seems low: only 1 of the 4 criteria must be met for a center to be counted as "integrated."

Activity	Current Result	Current Indicator	Indicator Definition	What's the Problem?
AFPP	(SO) Improved Selected Health Care Services in Target Areas	% of service delivery points providing family planning services	# of SDPRO Shëndetit with commodities, trained provider(s), IEC materials/total # of SDPRO Shëndetit	The problem here is more subtle, and gets at the real, higher-level meaning of the SO. The definition of the indicator is good, but the indicator is a measure of increased supply of FP *anywhere* (any SDP). The SO, however, is about better primary health care. A small but important change could fix this: changing SDPs to HCs/HPs—the same HCs/HPs where USAID's other work focuses—would truly measure better (improved) health services.

Recommendations

- *Conduct a thorough review of the PMP as part of the Mission's new strategy exercise and define refinements to the SO 3.2 Results Framework (USAID/Albania with Contractors)*

- *Ensure that indicators and definitions are well-matched and "set the bar" at the highest realistic level. Indicators at the SO level should help tie the intermediate results together conceptually—creating a whole that is greater than merely the sum of its parts, and should measure the stated result rather than another result. (USAID and Contractors).*

3. Issues in Program Implementation

The context for the program makes implementation a challenge. As described above, Albania's current primary health care system is often fragmented, redundant, and guided by unaffordable expectations. There is an extensive network of over 2,500 staffed public outpatient facilities. Yet, health centers and health posts rarely offer a truly integrated package of PHC services and the client population often by-pass the first line facilities. Services are often curative in nature, and do not offer some of the more important preventive services. For example, some clinics write of prescriptions for chronic conditions (heart disease, diabetes) but do not give simple life style advice such as "quit smoking," "exercise," and "eat healthy." There are not always easily available preventive services through the PHC centers such as immunizations or pre-natal care for pregnant women. This fragmentation, results in inefficiency, low productivity and client inconvenience.

There is also evidence of redundancy—such as when a health post exists in very close proximity to a health center, or where health centers offer overlapping services with nearby women's consultation rooms. Finally, through interviews with key informants and in the field direct observation of structural and human resources, the team found that expectations

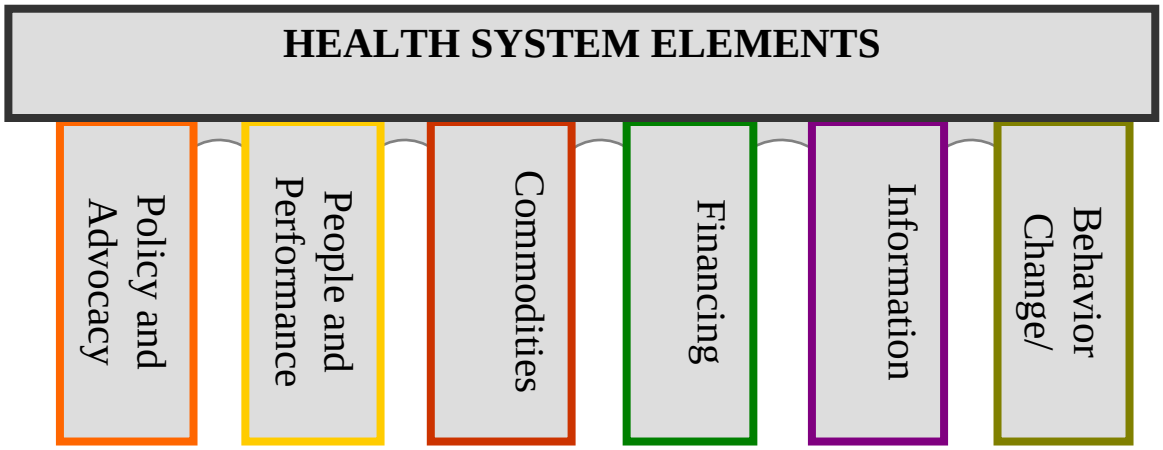
of coverage and access are still more in line with Albania's former system or dream of "universal coverage" than with a more modern, rational use of finite resources. To further complicate things, although the private sector is still relatively small, its importance in providing outpatient services is growing. If the government were to decide to privatize primary health care services as it did pharmaceuticals as some suggested, the program strategy would have to be drastically revised. In sum, the current PHC system in both the public and private sector requires much work to be done. Fundamental changes are needed in the way that primary health care is financed, delivered and organized.

The overall program results are good for the "first real year" of operations by PRO Shëndetit and AFPP. But the program may need adjustment over the next few years to be more focused and have stronger end results. The strategic approach developed by the team outlines concrete steps to do this. Also, the donor policy paper (See Annex C.2) identifies four major actions to improve service delivery:

- Upgrade clinical effectiveness
- Change the incentive framework for providers,
- Establishing a quality assurance system and
- Further consolidate reforms in the pharmaceutical sector.

Right now, the program has meaningful activities in the major elements or building blocks of a health system show in the figure below. Figure 4 graphically depicts the program elements consistently identified as essential in health delivery systems around the world. [18]

Figure 4: Health System Elements



But as this paper's strategic approach suggests, these elements cannot be developed in isolation but rather must be combined to create a fully functioning service delivery site. The essential pieces include a favorable legal/regulatory environment, empowered and skilled providers, essential services, stocked and equipped facilities, adequate financing, and informed clients. At this early stage, program activities appear vertical and disconnected. Exactly how and when the pieces will come together in the current program

[18] Reference Materials CD from Health System Strengthening Training, USAID Global Health Bureau.

is not clear and how they ultimately will impact on health care is not always evident. As the program matures, it will be important to keep the focus on the end game.

Policy work has taken place but increased policy dialogue, at the highest levels, is needed to ensure program success. The program, to establish structures and systems, has addressed or will need to address a number policy issues that overcome legal and regulatory barriers at the operational levels. For example, to improve the financing of primary health care, *PROShëndetit* plans to define the potential roles, responsibilities, and contracting processes for providers to gain more autonomy. The new health information system requires new ministry-wide MOH guidelines on manpower development in the use of the system. To support and maintain the changes being introduced in provider competencies, new implementing regulations, service guidelines and provider performance standards are also necessary. These endeavors are likely to include awarding points to health professionals and giving those credits towards certification as family physicians; improving the rating or accreditation of the health center where they serve; and providing payment incentives for performance or adherence to higher standards of care.

To ensure that the program is fully coordinated with the government and other donors and that the legal regulatory and policies are in place, considerable policy dialogue is needed to make the program successful. GOA, with USAID, all donors and partners, should develop and adhere to a more focused strategic vision with clearer end results. All partners should work to coordinate parallel program activities to ensure realistic expectations; sufficient attention to policy, regulatory and supply consideration; reduce redundancies and fragmentation. USAID should define its leadership role and more effectively engage USG officials at various levels in greater policy dialogue to ensure that the necessary legal, regulatory, financial, management and supply systems are put in place to support effective primary health care delivery and other essential public health activities. Senior USG dialogue is particularly important in the area of health financing;

Right now, program definitions are not precise. One particular policy area needing immediate attention is in definition of the program and synchronizing program implementation. The team believed that current program definitions (such as, integrated, intervention package) are unclear or inadequate. It would serve the citizens well if a major effort was made to help the government define a realistic and affordable set of PHC services that meet the needs of Albanians and are considered of "value and use."

Currently, as defined in the PMP, "integrated primary health care" refers to any service delivery point (SDP) where:

- An update and refreshers in basic skill improvement (e.g. family planning, HIV/AIDS, TB, antenatal and child health) have taken place for the general practitioners or nurses and midwives;
- The new management information is in place;
- Quality improvement is being undertaken by SDP; or
- Clinical performance improvement for general practitioners models is being taught.

While all four of these activities will eventually take place at all SDPs, inventions are now implemented in a staggered fashion. At this point, only one of the activities has to be undertaken for a SDP to be counted as "integrated." Thus the measurement may not be an accurate indication of success. Perhaps it would be more appropriate to design some "hierarchy of results" that could measure progress toward ultimate success.

Moreover, there needs to be greater clarity regarding the use of the intervention package. The statistics from Berat Prefecture compiled from the patient encounter form showed very few SDP encounters for basic PHC services i.e. maternal health, child health, family planning, tuberculosis (TB), HIV/AIDS, disease protection and prevention). By contrast, a list of services available by site reported in the PHRplus *Baseline Survey of Basic Health Services Utilizations, Expenditures and Quality* showed ample PHC services at the ambulatory and rural clinics, but less so at the urban centers.

Currently, most PHC encounters for chronic non-communicable diseases by protocol end up in referral. Perhaps skills development and service delivery should emphasize the preventive and disease management services actions that could be implemented, as appropriate, at the primary heath care level--for example, using the visit for life-style education to counsel cardiac as well as diabetic patients, in addition to writing drug prescriptions or sending the patient on to the specialist. There also seemed to be missed opportunities to provide PHC services. For example, during prenatal/postpartum services, it would be an opportunity to introduce family planning; the well baby clinic would offer the opportunity to teach exclusive breastfeeding, importance of good nutrition, identification and treatment of childhood diseases. Periodically it will be important to look at the service delivery package from the perspective of the client—Does the client get what services he/she needs, when and where needed?

In seeking an answer to what is included in the services package, the team could not find an explicit definition for any service except for family planning which is well-defined by both AFPP and *PROShëndetit.* There is a notional list of clinical skills to be incorporated into PHC practice listed in *PROShëndetit* 3 Year Strategic Plan (page 30). The team believes that it is imperative that the program step back and with the government define clearly what exactly the PHC services package includes, what services should be delivered at what level, and assess what needs to be done to align interventions more systematically.

Coordinated implementation is not totally evident. The team observed what appeared to be almost vertical implementation of individual program activities. For example, *PROShëndetit's* health encounter form provides some important information on patient visits for those with health insurance. The team saw good examples of health providers using the information on client services provided to examine their own or colleagues work. However, it is **not** clear, for example:

- How the encounter form tracks some of the PHC interventions such as family planning, immunization, well-child care, prenatal visits, which are priorities for the program.
- How the form connects or will connect to the FP logistics management system for contraceptive resupply.

- How the form has (or will) connect to the multiple registers or other forms that are filled during a client visit to a facility.
- How the uninsured are counted and tracked using the form.
- How the form interfaces with the paperwork now required for insurance reimbursements.
- How the form links to performance payments for quality service delivery.
- How the form links to referrals or outreach.
- How the data collected is used or could be used for programmatic decision making.

The team does agree that the further development of the health management information system should move forward. The patient client encounter form is an excellent initiative in a country with no electronically accessible information. **However,** the current effort should be viewed only as the first step in a larger more comprehensive management information system. The team strongly believes that groundwork must be laid now for a more sophisticated information system. In addition, the team believes that USAID and *PROShendatit* should step back, analyze the potential for the HMIS and develop a comprehensive strategy a more complex system. If considerable thought is not given now to expected end result of the health management information system, the program risks having to jettison hard earned efforts on the current system.

Implementation actions are uneven. USAID's projects have created very strong program pieces for a better primary health care system. But there does not appear to be a critical mass of health centers that have a cohesive, integrated, effective PHC that include the priority PHC services that meet clients PHC needs. The team believes that it is important to have a significant number of well-functioning PHC centers to demonstrate the effectiveness and efficiency of the whole program before rolling out the individual program components. In other words, the team recommends more focus on "depth" before focusing on geographic breadth. It is time to consolidate pilot efforts to improve clinical effectiveness and quality of care as donor policy notes have clearly recommended.[19]

The current program efforts are targeted to the rural populations, yet Albanians are increasingly moving to urban areas. There appears to be consensus that Albania is becoming more urbanized. It is estimated that almost one third of the population is in Tirana and the surrounding prefectures. Repeatedly the team was told that the civil registration in the rural areas was not being corrected as people moved to Tirana or elsewhere. Thus, it is important for the program to continue to implement appropriate services for the rural populations but also it needs to consider appropriate services for the increasingly urban population. This action could dovetail nicely with improvements in civil and voter registration, and possibly insurance registration.

Recommendations

- *Engage USG officials at various levels in dialogue with the Government of Albania to ensure that the legal, regulatory, financial, management and supply barriers are*

[19] See Donor Policy Notes, Annex C.2, with particular note of Recommendation 31.

removed so effective primary health care can be delivered. (GOA, USAID, donors and all implementing partners).

- *Develop, with other donors, a operational agenda that will focus strategically on the expected outcomes, and collaborate with partners to remove barriers, ensure realistic expectations, and reduce programmatic redundancies and duplication, including:.*

  - ✓ *Assist the government in defining a realistic, evidence-based and affordable set of essential primary care services, and the related provider roles, that meet the needs of Albania's rural, and increasingly urban, population. Client help in defining these needs is very important. (USAID and Contractors)*

  - ✓ *Define more precisely what is meant by "integrated primary health" and consider developing a hierarchy to measure progression of success.(Contractors)*

  - ✓ *Develop a coordinated program plan that better integrates various interventions to ensure coherence and synergy.(GOA with Contractors)*

  - ✓ *Focus program interventions on those actions that will lead to the expected end-result of "Better Primary Health Care." (Contractors)*

- *Seek programmatic depth before proceeding to geographic width. Develop a critical mass of health centers and affiliated health posts that deliver a well-defined set of essential PHC services that are wanted and needed by the client. (GOA with Contractors)*

- *Consider developing service programs and approaches that also meet the needs of the increasingly large urban population. (GOA with Contractors)*

4. Opportunities for Cross-Sector Impact

There are promising linkages between USAID/Albania's health program and its other program areas. This is especially true in two areas: increasing citizen/community empowerment in local governance and reducing corruption.
First, the appraisal team observed that health activities are already contributing to increased citizen/community involvement in local governance—exactly the kind of result the Mission seeks in democracy/governance.

In Lezhe, for example, the Director of Primary Health Care articulated the positive impact of *PROShëndetit*'s training in "COPE,"[20] a facility-level quality improvement tool. He

[20] COPE stands for the performance improvement program, Client Oriented Provider Efficient. It is a quality improvement tool that staff at a given health facility use to analyze the problems/needs of the facility and find ways to solve them.

reported that COPE brought "a totally new way of thinking in Albania," in that "we could solve some of our own problems." He offered an example of one health center that—following the COPE analysis—successfully lobbied the mayor's office to provide funding to install running water to the center. The team heard additional, independent support for this while visiting an actual health center. A head doctor and team of nurses proudly reported not only minor improvements they had made themselves to their clinic (following COPE), but that they had "more motivation, confidence, and information" to make requests to the local government. Their first request was simple, but successful and important to their patients: that the local government provides benches for patients to sit on as they waited.

A second important opportunity for a cross-linkage to another Mission goal is reducing corruption. The health sector offers tremendous potential to "put into practice" theoretical frameworks and strategies for fighting corruption, such as those outlined in the E&E Bureau's recent anti-corruption framework known as TAPEE (Transparency, Accountability, Prevention, Enforcement, and Education). In Romania, for example, USAID's health officer, Gabriela Paleru, identified the following actions and effects for corruption in health. (Annex E offers additional examples from USAID/Georgia.)

Table 4: Corruption = Monopoly + Discretion - Accountability

Action	Likely Effect
Create appropriate Essential Drug Lists (EDL)	Limit influence/discretion of interest groups
Use Standard Treatment Guidelines as basis for EDL	Promotes transparency and accountability
Employ indicator-based assessments and monitoring programs	Detect unusual selection and purchasing patterns
Public disclosure of inspection findings	Increases transparency and accountability

Fortunately, the current activities and plans of USAID/Albania, *PROShëndetit*, other donors, and most importantly the new Albanian government are very well aligned to advance an anti-corruption agenda in health. USAID/*PROShëndetit*'s plans in health financing reform should introduce transparency and accountability for the funding of primary health care services.[21] *PROShëndetit*'s health promotion activities and COPE training will continue to inform patients and providers of their rights and responsibilities (the Education part of TAPEE).

Thirdly, *PROShëndetit's* health information system work provides the foundation to track and monitor (Prevention and Enforcement). As for other donors, a collection of donor policy notes to the new GOA did not mention "corruption" by name, but clearly included several types of reforms that follow the TAPEE paradigm. Most importantly, the new

[21] At least in one prefecture, Berat, within the next year, this will require strong support from USAID, as detailed in the special section C on Health Finance Reform.

Government of Albania has strongly and publicly committed to reducing corruption. The health sector is one where USAID can help the GOA make good on that commitment in a tangible way.

One area that warrants a look for potential corruption is the patient fee of "200 leke." The team noticed in each health center the 200 leke fee was prominently displayed. When the providers were asked the procedure for collecting the money, few could answer. Some stated that many clients could not pay the fee, so they did not collect the fee and the visit was not reported. If the fee was collected, several providers noted that there was no protocol for handing or accounting for the funds. While in most cases posting fees would be seen as a measure to prevent under the table transactions, in this case the reported ambiguity could result in underreporting of services or misuse of funds.

Recommendation

- *Look for, build upon, expand and report on USAID's health program contributions to the USG's goals in democracy/governance and anti-corruption (USAID with Contractors).*

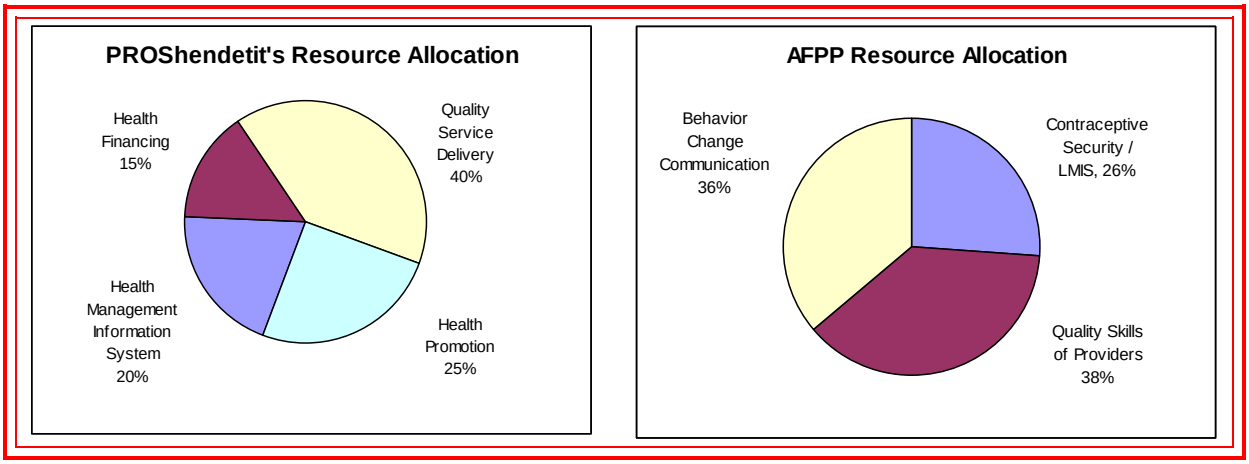
5. Resource Management

The USAID and contract staffs in Albania are talented and committed. In the last year, program staff have accomplished much and are functioning as a high performing team. A critical ingredient in this improved program performance has been the appointment of a senior health advisor with broad experience and excellent management skills as the URC chief of party. It is very important that this level of expertise and senior executive perspective be in place to maintain focus, guide the program, orchestrate the various program parts and work with USAID and the GOA on ensuring the overall soundness of the program and the appropriate pace for expansion or rollout. Succession planning should be undertaken to ensure that the program retains a person, as chief of party with the same caliber as the current Chief of Party if he were to leave.

In the case of the USAID health officer, it is expected that she will assume greater responsibilities for policy dialogue and donor coordination. It will be important for the mission to invest in further leadership and management as she takes on these greater responsibilities. In addition, to do all that she needs to do and is capable of doing, she needs backup support from a program assistant.

For the initial programming, the financial support has been appropriate. The program funds allocated are shown for both *PROShendetit* and AFPP in Figure 4.

Figure 4: Project Funding by Category



The team does not have enough information to comment on the current budget allocation. However, the resource allocations should be monitored carefully as the program matures and the program extends activities to new geographical areas. The appraisal team was struck by the number of "process" or contract management visits in contrast to the number of "technical" or program enhancement visits made by the contractors' home office staff. The team hopes that in the future year, most of the contract management activities will have been completed and that more needed technical visits or direct in-country assistance activities will be conducted to reinforce the technical soundness of the program in Albania.

There are some factors external to the current program that may impact significantly on financial resource management. Given changing needs as indicated by the new government's priority for PHC and USAID's increased ability to influence national policy, a reallocation of funds may be needed to support policy dialogue activities. It is important to engage senior USG leadership, such as the Ambassador and the USAID Mission Director, in policy dialogue to support the government in decisions regarding the use of resources for health, corruption, and priorities for meeting Albania's population's evolving needs. It is likely, however, there will not be an increase in mission funding. Therefore there may have to be some reallocation among the current line items.

Often in this type of broad health program, there is always a tendency to let "all flowers bloom." While the program staff may want to be responsive to all constituencies, they may have to be restrained by the funding available. This makes the choice of program activities more critical. It will be imperative that USAID and the program contractors maintain careful balance of program resources and always check the "so what?," "what else?" and "is there value added?" in programming. In rolling out the PHC program to additional health centers it will be important to establish criteria for which centers will receive this assistance. Among these criteria, the team recommends consideration of:

- Availability of other donor funding or potential for leveraging,
- Local government or community support,
- Providers interest and willing to innovate, and
- Actual or potential large client base.

.

Also, the combined staffs must monitor the progress to assure that resources are used for maximum impact. Although not with project activity per se, the team observed costly redundancies, and what appeared to be excessive expectations in some of the existing service delivery sites. For example, the team visited several women wellness centers well-designed, with ample and fully trained staff, well-equipped, and stocked with materials and supplies. However, each of these reported only 3-4 patients per day. At the same time, there were health centers within blocks with many clients but no family planning services. An examination of the costs associated with multiple centers, client loads and the reasons why clients use or do not use a particular facility might suggest important alternatives.

The underlying question should be that there will be return on the investment of program resources. As the present Chief of Party notes, "you can lead a water buffalo anywhere, as long as the buffalo wants to go there." Given the reported low use of current health centers, it is important to involve clients' in planning in order to meet client needs and prove "worth" of the services to the citizens. In addition, an outreach program and aggressive multi-dimensional behavior change and communication program will be critical to increased knowledge of and use of services. An educational campaign should include all types of interventions directed to the general public, group and individual audiences

Recommendations

- *Review carefully the current budget and realign as appropriate as the program is maturing, USAID's new health strategy further evolves, and new government plans become known. (USAID with Contractors).*

- *Continue to invest in the development of the local USAID and program staff to develop further in-country capacity to plan, develop and monitor health activities. (USAID and Contractors)*

- *Provide support to the current USAID health officer to enable her to engage more fully in greater policy dialogue and donor coordination. The team recommends the addition of a program assistant to help with the operational aspects of program oversight and monitoring. (USAID)*

- *Develop criteria to select those health centers which will receive program assistance. (Contractors).*

- *Make resource allocations decisions based on the potential for "optimal use of funds" and "maximum impact." (USAID and Contractors)*

C. A SPECIAL CASE – HEALTH CARE FINANCING

Financing in the health care system is of utmost important to the successful delivery of primary health care. The section addresses specific questions raised to the team by the mission**.**

Why is a special focus on health financing (HF) needed?

USAID *and PROShëndetit's* goals in health financing reform merit a focused, strategic look for a few reasons. First, by *PROShëndetit'*s own reports, the past achievements and current status of the project's HF component are less clear than the other components. Second, in terms of resources invested relative to expected results, the HF component of USAID's *PROShëndetit's* work is probably the riskiest gamble, but also the one with the biggest potential payoff. It is risky for two reasons: 1) it requires future GOA actions (passing decrees, laws) that are more politically and technically difficult than in PS's other components; and 2) the past record casts some doubt that these actions will happen in the near term, as they have been agreed upon in theory but not implemented for nearly a decade. The recent change in government, however, may offer an opportunity for advancement, and *PROShëndetit* staff are optimistic about making important progress very soon. Given these realities, it is especially important to make sure USAID and PRO Shëndetit agree on goals, work plans, and benchmarks for the HF component.

What is the strategic fit of the HF component for USAID and Albania?

The project's "Two-pager: *PROShëndetit'*s Health Financing Activities" provides a convenient snapshot of the problem of financing for primary health care, which in sum is insufficient, fragmented, non-transparent, and inefficiently allocated. *PROShëndetit* focuses on three objectives to improve the system: 1) implementation of single-source financing, 2) introduction of autonomy of providers, and 3) introduction of performance-based contracts. These objectives clearly contribute to USAID's sub-IR 1.1, "Health financing system improved," and USAID's IR 1 "Health resources efficiently managed." They also contribute to USAID's overall goals in improving Albania's governance, efficiency, transparency and accountability (anti-corruption), and progress toward EU integration.

Compared to *PROShëndetit's* other three components, it is harder to make the case for HF's *people-level* health impact, especially in the near term. But put simply, Albania does not currently have a modern, sustainable health system. It is unlikely to build one without the kinds of financing reforms at the primary care level that USAID supports. **The overall strategic fit, therefore, is good.**

More specifically, there is broad consensus in the literature over the past three years that creating a single-source payer for health is vital to improve Albania's health system over the long term.[22] Experts inside and outside the government agree that making SSP a reality

[22] See documents from PHRplus, World Bank, PS, Donor Policy Notes to GOA, and GOA's own Long-Term Strategy.

should increase transparency and accountability in the health sector. This will improve the GOA's ability to monitor financial flows and services provided and make sound policy decisions based on accurate information.

USAID/*PROShëndetit's* efforts to create autonomous providers and performance-based contracts are also key to long-term sustainability of USAID's health investments, and more importantly to primary health care for Albanians. "Autonomous providers" refers to health centers gaining the right and the means to organize the provision of services to best meet the needs of the local population. Introducing "performance-based contracts" means providers will be paid based on the number and—at least in terms of client demand—the quality of the services they provide, rather than the passive, static, and outdated current basis that relies primarily on the number of people registered as residents in the health center's catchment area. The new system will link providers' salaries with the number of patients they actually serve and allow patients to "vote with their feet." Especially with weak top-down supervision, the most sustainable option for improving quality and efficiency in primary health care is a financing system that incorporates these two principles. The result will be continuous quality-improvement and de facto performance monitoring from the bottom-up.

There is clear evidence that the GOA is committed to HF reform at the primary care level at least in theory, though it is still unclear whether the new GOA has the political capital to make reform happen. If it does, USAID has a solid history and current comparative advantage in helping the government achieve this. Indeed, USAID is likely the only donor interested and able to support the needed reforms at that level. In sum, the appraisal team generally agrees with *PROShëndetit*'s staff that "the potential (of HF reform) seems too good not to respond as strongly as possible," but that the coming year will be critical to deciding how and whether USAID continues to invest in HF.

Are USAID/PS resources used optimally to achieve goals in HF?

invests approximately 15% of its resources on HF. Over the past year, this investment resulted in a number of activities that raised awareness of, laid the foundation for, or analyzed the HF situation. These included study tours for policy makers and providers to the Czech Republic and Lithuania, workshops for providers inside and outside the Berat pilot prefecture, and a situational analysis of HF reform. *PROShëndetit* recently hired new staff and now employs an effective two-person HF team, combining the expertise and technical credibility of an expatriate HF/E&E expert with the additional expertise and local political/cultural know-how of an Albanian HF specialist.[23] In the coming year, *PROShëndetit* plans to emphasize technical/policy assistance to the new GOA and financial management training and technical assistance in performance-based contracting with autonomous providers.

[23] Key informants such as a former Deputy Minister of Health now employed by *PROShendetit* remarked that foreign experts are very helpful in certain policy dialogue and advocacy with the GOA, including HF reform.

The appraisal team questioned—but did not have enough to explore and answer fully—whether some of the HF activities of the past year were optimal in terms of advancing the HF agenda. Were the study tours vital and did they result in advances? Was the situational analysis necessary after many other analyses of HF by PHRplus, World Bank, WHO, and others had been written? Was conducting workshops for providers in Lezhe—outside the pilot prefecture of Berat—properly-timed given that the reforms had not started in Berat?

Despite these questions, the team found that project staff have good knowledge of what the major implementation obstacles have been and continue to be, and that the program is **generally on the right track** with HF. The *PROShëndetit* Annual Report clearly identifies the major implementation obstacles the project faced in the past year. They are:

- Lack of clear objectives, timeline, and benchmarks among donors and GOA to achieve the HF reforms;
- Lack of clear roles/responsibilities among GOA institutions and donors; and
- GOA failure to pass needed legislation/regulations to start testing single-source payer, autonomous providers, and performance-based contracting in Berat.

The Mission and project staffs now need to ensure that their efforts are well-targeted to overcome these obstacles. Only then will the on-the-ground technical assistance in implementing new systems (e.g., training providers in financial management) have meaningful impact.

Is USAID/*PROShëndetit* having the right impact in HF?

Project staff and written reports point out that the status of HF is less clear than the other project components, and those ultimate results are critically dependent on the GOA. Project reports, site-visits, and discussions with staff, however, provide reassuring evidence that HF is "simmering." *PROShëndetit* has accomplished a number of activities that help lay the ground work for future implementation (technical assistance and trainings for future autonomous providers, awareness-raising among decision makers, policy discussions, etc.). Despite some significant progress, a number of factors—the election primarily—caused necessary GOA reforms to stall. The big picture view of USAID's impact on HF, therefore, has not changed much since the last years of PHRplus's work. The analysis of the problem exists, the strategy for addressing it exists and enjoys general consensus, and preparatory work at the health center level has occurred. The need now is to work closely with the GOA to determine whether real implementation and experimentation on the ground can begin.

The discussion above brings forth several operational considerations: a) For both current and potential efforts, HF should be more closely with health promotion work, in order to raise awareness and "build demand" for HF-related from the ground, especially while the "supply" of HF reform is stalled.; b) If an extra push is needed in the next year to advance policy and work more closely with the GOA, the project should consider additional support for the two-person HF team; c) The project might consider placing one of 's HF experts in the MOH or HII to increase policy engagement and better enable the GOA to use *PROShëndetit* as a resource; and d) The project may weigh further "foundation-

building" activities very carefully from now on (e.g., study tours, workshops outside pilot prefecture, etc.).

Recommendations

- *In the coming year, target the major implementation obstacles from the recent past. Clearly define objectives, timelines, benchmarks, and roles and responsibilities among the GOA, donors, local governments, and the private sector. Consider alternative courses of action if pilot implementation in Berat continues to be blocked. (Contractors)*

- *Make sure USAID's health financing's focus stays at the PHC level. Encourage other donors to tackle other essential reforms, such as hospital financing and changes in the collection of health/social insurance contributions. (Contractor)*

- *Provide USG leadership (especially the Ambassador and USAID Mission Director) with clear opportunities to advocate for HF reforms with the GOA. (USAID backed by Contractors)*

IV. MAJOR CONCLUSIONS

In summary, the team wishes to reaffirm that "we liked what we saw." The team met many dedicated Albanian health managers and providers. The current program has talented staff and most of the pieces needed to help Albania improve care for its citizens by strengthening primary health care. The USAID health assistance program contributes directly to the U.S. Mission to Albania performance plan goals in democracy, economic growth and friends and allies with its empowerment of communities, reduction of opportunities for corruption and help in helping Albania prepare for European Union integration and Millennium Challenge Account eligibility.

This is an opportune time for USAID to be developing its next strategy as the new government sets its priorities in health and other donors develop their new plans. Of particular importance is the World Bank $10 million, five year loan which will reinforce and help rollout many of the activities USAID-funded projects are developing with the Government of Albania.

The team believes it is important now to pull together the various program activities and ensure that these improved systems and support for providers function together at health centers so that essential, improved primary care is available to Albanians. It is important that clients be involved in determining both the package of services and how these can best meet their needs. A strategic approach lays out a three step program for determining what is a needed in health centers, testing and implementing this model and rolling it out to reach significant numbers of Albanians.

Health financing is the part of the USAID-assisted program which has the highest risk and potential gain. A separate brief analysis in the report summarizes some of the challenges and gains. USG policy dialogue and other support will be very important in helping the new government it make and implement hard and high political capital decisions on health center investment, provider reimbursement and system rationalization. These and other client actions must be monitored by mission and program staff to ensure that the program conforms to political, operational and client realities. The new government's political will and capital are essential for success. .

In the report, the team offered a number of recommendation, technical suggestions and operation considerations. In brief, these revolve around the need to:

- Develop and adhere to a more focused strategic vision with clearer end results and work to coordinate parallel program and donor activities to ensure realistic expectations; sufficient attention to policy, regulatory and supply consideration; reduce redundancies and fragmentation and define better USAID's role;

- Engage at USG officials at various levels in greater policy dialogue with the Government of Albania to ensure that the necessary Albanian legal, regulatory, financial, management and supply systems are put in place to support effective

primary health care delivery and other essential public health activities. Senior USG dialogue is particular important in the area of health financing;

- Assist the government in defining a realistic, evidence-based and affordable set of essential primary care services, and the related provider roles, that meet the needs of Albania's rural, and increasingly urban, population. Client help in defining these needs is very important.

- Ensure the program assistance in health financing stays focused at the PHC (health center) level, which is within USAID's capacity to improve. As necessary, encourage other donors to tackle other essential reforms, such as hospital financing and changes in the collection of health/social insurance contributions.

- Ensure that a critical mass of health centers and affiliated health posts, each deliver a well-defined set of essential integrated primary health care services, including immunization and family planning and have strong outreach programs. Developing sound criteria for selecting the health centers will be critical.

- Review and update the PMP to ensure that the indicators match results and that the mission and the program have a sound basis for tracking, analyzing and reporting results. It is especially important that indicators at the SO level help tie the intermediate results together conceptually—creating a whole that is greater than merely the sum of its parts. The PMP will also need to include the agency "common" indicators in health, most if not all of which can be drawn from international reports.

- Invest in USAID and program staff. The present staffing includes many talented individuals who would benefit from broader exposure to senior planning and management training.

- Review carefully the current budget and realign resources as appropriate as the program is matures, USAID's new health strategy further evolves, and new government plans become known.

STRATEGIC APPRAISAL

USAID/ALBANIA HEALTH STRATEGY AND PORTFOLIO

ANNEXES

ANNEX A

RECOMMENDATIONS

Strategic Relevance, Focus and Coherence

- Set a health objective for the new USAID strategy statement along the lines of "Better Health Care for Albanians" as proposed in this report. (USAID)

- Take a more active leadership role with other donors and support the development of a common agenda for policy dialogue and donor assistance (USAID).

- Maintain a U.S. health policy agenda and use the full U.S. presence for policy dialogue on health with the new government (US Ambassador, USAID Director, other USAID staff and program staff).

Results Measurement

- Conduct a thorough review of the PMP as part of the Mission's new strategy exercise and define refinements to the SO 3.2 Results Framework (USAID/Albania with Contractors)

- Ensure that indicators and definitions are well-matched and "set the bar" at the highest realistic level. Indicators at the SO level should help tie the intermediate results together conceptually—creating a whole that is greater than merely the sum of its parts, and should measure the stated result rather than another result. (USAID and Contractors).

Program Implementation

- Engage USG officials at various levels in dialogue with the Government of Albania to ensure that the legal, regulatory, financial, management and supply barriers are removed so effective primary health care can be delivered. (GOA, USAID, Donors and all Implementing Partners).

- Develop, with other donors, a operational agenda that will focus strategically on the expected outcomes, and collaborate with partners to remove barriers, ensure realistic expectations, and reduce programmatic redundancies and duplication, including:

  - ✓ Assist the government in defining a realistic, evidence-based and affordable set of essential primary care services, and the related provider roles, that meet the

needs of Albania's rural, and increasingly urban, population. Client help in defining these needs is very important. (USAID and Contractors)

- ✓ Define more precisely what is meant by "integrated primary health" and consider developing a hierarchy to measure progression of success. (Contractors)
- ✓ Develop a coordinated program plan that better integrates various interventions to ensure coherence and synergy. (GOA with Contractors)
- ✓ Focus program interventions on those actions that will lead to the expected end-result of "Better Primary Health Care." (Contractors)

- Seek programmatic depth before proceeding to geographic width. Develop a critical mass of health centers and affiliated health posts that deliver a well-defined set of essential PHC services that are wanted and needed by the client. (GOA with Contractors)

- Consider developing service programs and approaches that also meet the needs of the increasingly large urban population. (GOA with Contractors)

Cross-Sector Linkage

- Look for, build upon, expand and report on USAID's health program contributions to the USG's goals in democracy/governance and anti-corruption (USAID with Contractors).

Resource Management

- Review carefully the current budget and realign as appropriate as the program is maturing, USAID's new health strategy further evolves, and new government plans become known. (USAID with Contractors).

- Continue to invest in the development of the local USAID and program staff to develop further in-country capacity to plan, develop and monitor health activities. (USAID and Contractors)

- Provide support to the current USAID health officer to enable her to engage more fully in greater policy dialogue and donor coordination. The team recommends the addition of a program assistant to help with the operational aspects of program oversight and monitoring. (USAID)

- Develop criteria to select those health centers which will receive program assistance. (Contractors).

- Make resource allocations decisions based on the potential for "optimal use of funds" and "maximum impact." (USAID and Contractors)

Health Care Financing

- In the coming year, target the major implementation obstacles from the recent past. Clearly define objectives, timelines, benchmarks, and roles and responsibilities among the GOA, donors, local governments, and the private sector. Consider alternative courses of action if pilot implementation in Berat continues to be blocked. (Contractors)

- Make sure USAID's health financing's focus stays at the PHC level. Encourage other donors to tackle other essential reforms, such as hospital financing and changes in the collection of health/social insurance contributions. (Contractor)

- Provide USG leadership (especially the Ambassador and USAID Mission Director) with clear opportunities to advocate for HF reforms with the GOA. (USAID backed by Contractors)

ANNEX B

ECONOMIC, DEMOGRAPHIC AND HEALTH STATISTICS

1. Economic, Demographic and Health Data for Albania

2. Vulnerability Index: Country Ranking for 2005

3. Vulnerability Analysis: Albania and Selected Countries

ANNEX B.1

ECONOMIC, DEMOGRAPHIC AND HEALTH DATA FOR ALBANIA

	WHO	WB	UNDP	RHS	UNICEF
Population and General Development					
Population number (000)	3 130		3200		3166
Population in urban areas	45				44
Population under 15	28				
Population annual growth rate	-0.1	0.5	0.6		-0.3
Life expectancy at birth	74	74	74		74
Gross national income per capita	1 740	2080			1740
Population living below poverty line '(% with <1 $ a day)		25			
Literacy rate	92	99			85
Human Development Index			65/177		
Access to improved water sources	99	97			97
Access to improved sanitation	99				89
Adult literacy rate	98.7				
Mortality					
Death rate	5.79				5
Maternal mortality ratio (per 100 000 live births)	55				55
Probability of dying per 1000 live births under 5 years (under–5 mortality rate)	21		21	32	21
Infant mortality				26	
Before 28 days (neonatal mortality rate)	12	18	18	12	18
Fertility					
Total fertility rate	2.1		2.2	2.6	
Birth Rate	15.15				
Contraceptive Prevalence Rate (All Methods)				75	
Contraceptive prevalence rate (currently married-modern methods)				8	
Other Health					
Antenatal care coverage	81				95
Births attended by skilled health personnel	99		99		94
Newborns with low birth weight	3				
Children under-5 stunted for age	35				32
Children under-5 underweight for age	14		13.6		14
Number of adults and children HIV+	…				
Number of polio cases	0				
Immunization coverage (%) among 1-year-olds Measles	93		93		
DTP3	97				97
HepB3	97				
TB: new smear positive cases (per 100 000 population)	10				

VULNERABILITY INDEX 2005: COUNTRY RANKING

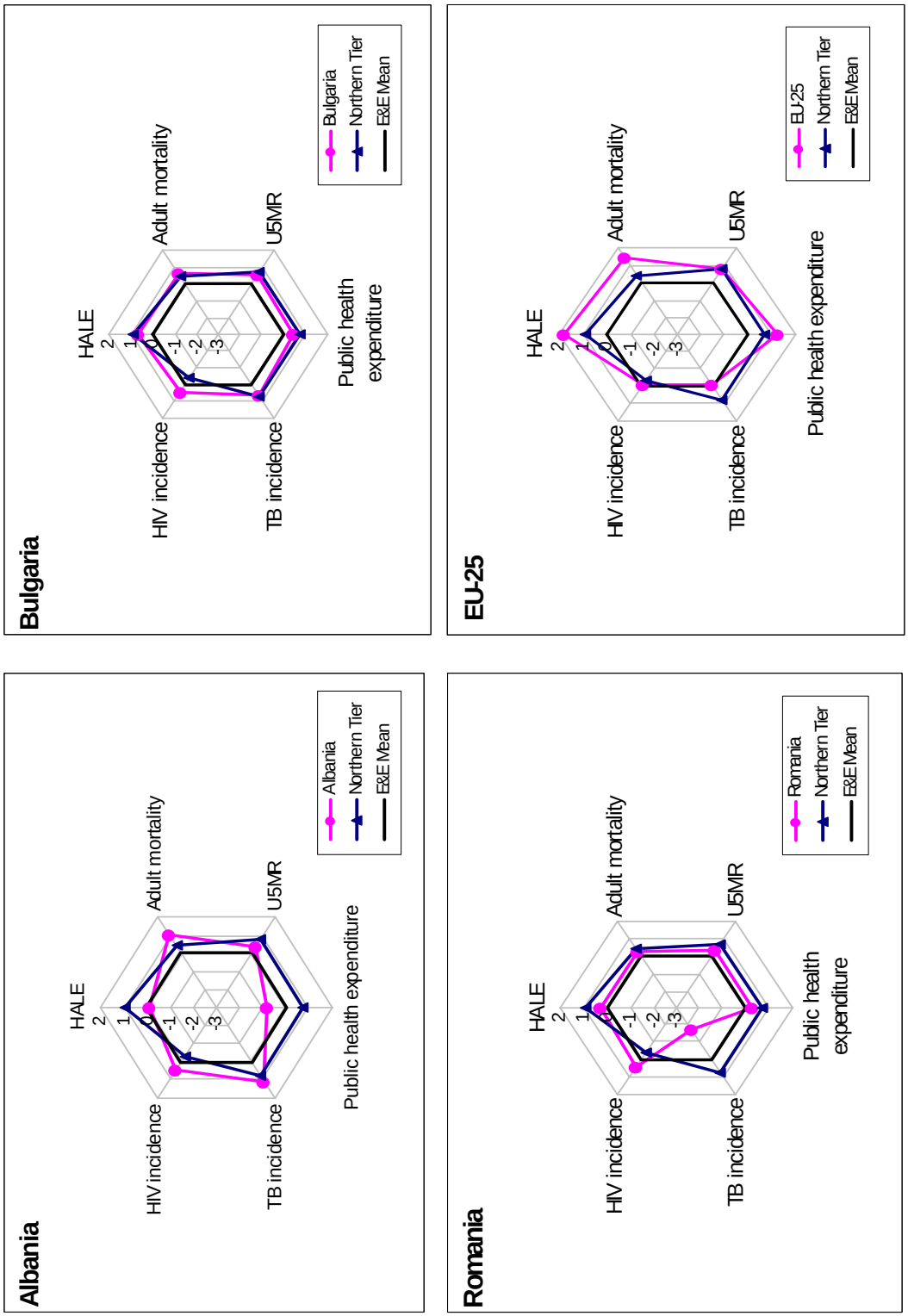
Vulnerability Analysis	Healthy life expectancy at birth, total			Adult mortality per 1000, total			Under 5 mortality per 1000 live births			Public health expenditure as % of GDP			TB incidence rate per 100,000 population			New HIV infection rate per million population					FINAL OUTCOMES	
	Year	Source	# of standard deviations outperforms (or is worse than) the E&E mean	Year	Source	# of standard deviations outperforms (or is worse than) the E&E mean	Year	Source	# of standard deviations outperforms (or is worse than) the E&E mean	Year	Source	# of standard deviations outperforms (or is worse than) the E&E mean	Year	Source	# of standard deviations outperforms (or is worse than) the E&E mean	Year	Source	# of standard deviations outperforms (or is worse than) the E&E mean				
Summer 2005	2002	WHO		2003	WHO		2003	WHO (World Health Stats)		2002	WDI		2003	WHR		2003	EuroHIV					
Country	Value	Rank		Value	Rank		Value	Rank		Value	Rank		Value	Rank		Value	Rank		Avg std dev diff	Rank	Rank	Country
Albania	61.4	16	-0.14	130	4	1.00	21	18	0.32	2.36	21	-0.84	23	3	1.10	6.6	7	0.43	0.31	11	1	Slovenia
Armenia	61	17	-0.24	172	14	0.24	33	20	-0.05	1.33	24	-1.47	70	15	0.04	9.5	12	0.41	-0.18	17	2	Czech Republic
Azerbaijan	57.2	23	-1.18	169	12	0.30	91	25	-1.85	0.82	27	-1.78	76	18	-0.10	13.9	15	0.38	-0.71	22	3	Croatia
Belarus	60.7	18	-0.31	243	22	-1.03	10	9	0.67	4.73	8	0.61	53	12	0.42	72.1	23	-0.05	0.05	13	4	Slovakia
Bosnia & Herzegovina	64.3	9	0.58	139	7	0.84	17	15	0.45	4.58	9	0.52	55	13	0.38	2.9	4	0.46	0.54	10	5	Macedonia
Bulgaria	64.6	7	0.66	152	11	0.61	15	13	0.51	4.45	10	0.43	43	9	0.65	8	10	0.42	0.55	9	6	Poland
Croatia	66.6	3	1.15	120	3	1.19	7	3	0.76	5.94	3	1.35	43	9	0.65	10.2	13	0.41	0.92	3	7	Hungary
Czech Republic	68.4	2	1.60	119	2	1.20	5	1	0.82	6.40	1	1.62	12	1	1.35	6	5	0.44	1.17	2	8	Serbia & Montenegro
Estonia	64.1	10	0.53	209	20	-0.43	8	4	0.73	3.89	15	0.09	50	11	0.49	671.9	27	-4.44	-0.50	19	9	Bulgaria
Georgia	64.4	8	0.61	133	5	0.95	45	21	-0.42	1.03	25	-1.65	83	19	-0.26	19.5	17	0.34	-0.07	15	10	Bosnia & Herzegovina
Hungary	64.9	6	0.73	181	15	0.09	9	7	0.70	5.48	5	1.06	29	5	0.97	6.4	6	0.43	0.66	7	11	Albania
Kazakhstan	55.9	24	-1.50	299	26	-2.05	73	24	-1.29	1.86	23	-1.14	145	25	-1.67	48.4	20	0.13	-1.26	26	12	Lithuania
Kyrgyzstan	55.3	25	-1.65	248	23	-1.12	68	22	-1.14	2.20	22	-0.94	124	23	-1.19	25.3	18	0.30	-0.96	25	13	Belarus
Latvia	62.8	15	0.21	205	19	-0.36	13	11	0.57	3.27	18	-0.29	75	17	-0.08	174.7	24	-0.80	-0.12	16	14	Romania
Lithuania	63.3	13	0.33	198	18	-0.23	9	7	0.70	4.32	12	0.36	70	15	0.04	31.9	19	0.25	0.24	12	15	Georgia
Macedonia	63.4	12	0.36	144	10	0.75	12	10	0.60	5.76	4	1.23	31	6	0.92	0.5	2	0.48	0.72	5	16	Latvia
Moldova	59.8	19	-0.53	224	21	-0.69	32	19	-0.02	4.07	14	0.21	139	24	-1.53	60.5	21	0.04	-0.42	18	17	Armenia
Poland	65.8	5	0.95	140	8	0.83	8	4	0.73	4.42	11	0.41	31	6	0.92	15.8	16	0.37	0.70	6	18	Moldova
Romania	63.1	14	0.28	171	13	0.25	20	16	0.35	4.15	13	0.25	149	26	-1.76	10.9	14	0.40	-0.04	14	19	Estonia
Russia	58.6	22	-0.83	321	27	-2.45	16	14	0.48	3.46	16	-0.17	112	21	-0.92	275.5	26	-1.54	-0.90	24	20	Ukraine
Serbia & Montenegro	63.8	11	0.46	142	9	0.78	14	12	0.54	5.09	7	0.82	35	8	0.83	9.1	11	0.41	0.64	8	21	Uzbekistan
Slovakia	66.2	4	1.05	139	6	0.85	8	4	0.73	5.27	6	0.94	24	4	1.08	2.4	3	0.46	0.85	4	22	Azerbaijan
Slovenia	69.5	1	1.87	116	1	1.26	5	1	0.82	6.22	2	1.51	18	2	1.22	7.1	9	0.43	1.18	1	23	Turkmenistan
Tajikistan	54.7	26	-1.80	197	17	-0.21	118	27	-2.69	0.91	26	-1.72	168	27	-2.19	6.7	8	0.43	-1.36	27	24	Russia
Turkmenistan	54.4	27	-1.87	261	25	-1.35	102	26	-2.20	3.04	19	-0.42	67	14	0.10	0	1	0.48	-0.88	23	25	Kyrgyzstan
Ukraine	59.2	21	-0.68	255	24	-1.25	20	16	0.35	3.34	17	-0.24	92	20	-0.46	206.3	25	-1.03	-0.55	20	26	Kazakhstan
Uzbekistan	59.4	20	-0.63	184	16	0.03	69	23	-1.17	2.50	20	-0.75	115	22	-0.99	70.4	22	-0.03	-0.59	21	27	Tajikistan
Standard Deviation	4.0			55.4			32.1			1.6			44.0			136.5					1=least vulnerable, 27=most vulnerable	
Mean	62.0			185.5			31.4			3.7			71.6			65.6						
United States	69.3			109.9			8.0			6.6			5.0			197.0						
EU-25 Mean**	69.2			111.1			6.2			5.7			73.8			89.1						

*Estonia's and Turkmenistan's HIV infection rates are for 2002. The U.S. rate is for 2003, reported by CDC. The E.U. rate excludes France, Malta and Spain.

**EU-25 mean is for the European Union-25, excluding Malta for lack of data.

ANNEX B.3

2005 E&E HEALTH VULNERABILITY ANALYSIS: RADAR GRAPHS FOR ALBANIA, BULGARIA, ROMANIA, AND EU-25 AVERAGE



1. HALE = Healthy Life Expectancy
2. How to read the graphs: For each indicator, the given country's level is plotted as standard deviations above (better than) or below (worse than) the 27-country USAID/E&E region mean, which is represented by the bolded zero line. For example, Albania's public expenditure on health as a % of GDP (Public Health Expenditure) is approximately 1 standard deviation below (worse than) the E&E mean.

ANNEX C

POLITICAL SETTING

1. **Except from New Government Plan, 2005-2010**
2. **Donor Policy Notes to the New Government**

ANNEX C.1

GOVERNMENT PROGRAM, 2005-2010

(Except on Health from the: "Government Program, 2005-2010" as presented by the Prime Minister to the Parliament on September 9, 2005)

…"High quality and honest health service with guaranteed access for all.

- The health system has deteriorated in recent years due to the slowing down and blocking of the reforms to establish a modern health system. Many indicators of public health have notably deteriorated. On one hand the outdated system, with poor performance and on the other hand, the poor living conditions and the impact of a polluted environment present a serious threat to the health of all and especially to children and the elderly.

- The Government pledges to carry out a fundamental reform of the health system at all levels and to accompanying the reform with a considerable allocation of public funds.

  - The reform in the primary care sector will combine decentralization with considerable investments for equipment, buildings and human resources, financed from public funds and those of the international partners and through the expansion of health care insurance. The effects of the reform will be felt in the increase of service quality; coverage of the whole country with health service; and, bringing the service as close as possible to the citizens. Special attention will be paid to the care of mothers and children.

  - The hospital system, which is outdated, will be developed through regionalization and concentration, aiming to enhance its performance. This reform will combine on one side the increase of discipline and on the other side the preparation and the inclusion of the hospitals in the system of health insurance. Increased amounts of public funds and funds from international donors will be also allocated to this sector.

  - The Government will declare frontal war on corruption in the health system, and will guarantee the medical discipline of service as well as the financial order of its administration. It will also increase the miserable salaries of this sector by 30-40% by the end of the first year of the mandate. The continuing training and mobility of medical personnel will take on special importance.

  - The public health sector will be reformed and modernized. The institutions of this network will be supported in their programs of disease prevention, especially in carrying out mass vaccination programs, health care promotion, drinking water and air quality control. The role of the local government in this sector will be expanded. This sector, in collaboration with that of primary care and hospitals, will develop and implement national projects for illnesses such as cancer, heart disease, AIDS, traumas, etc.

  - The Government will promote private sector participation in the health sector, in primary care, hospital and support services. Simultaneously, the Government will take care to avoid the conflicts of interest that may arise.

- The health insurance system will be reformed in order to increase the level of collection of mandatory contributions through the institutional strengthening of the Albanian National Health Insurance Institute. The Government will also promote the private initiative in the area of voluntarily health insurance.

- The government will take measures against the tendency of monopolies and conflicts of interest in the pharmaceutical market. The control and the guarantee of the quality of medications will be strengthened with the aim to have the Albanian market supplied by medications up to the level of European standards.

- Specific social groups will enjoy special service and/or discounts for health service and access of medications. Mothers and children, disabled individuals, retirees, etc. will enjoy special attention."

ANNEX C.2

POLICY NOTES FOR THE GOVERNMENT OF ALBANIA HEALTH SECTOR REFORMS

COMPILED FROM DONOR INPUT BY THE WORLD BANK

SEPTEMBER 2005

1. THE HERITAGE

1. **Albania's health care system prior to the transition was characterized by strong central government control over all aspects of the system.** Despite a widespread primary care network which had been established with a focus on antenatal care and immunization, Albania's pre-transition health care system was largely led by secondary care. The system was highly centralized, with the Ministry of Health providing and regulating all health services in the country and deciding on resource allocation and the nomination of health care staff. The construction of new facilities was favored over the maintenance and operation of existing infrastructure, which lead to considerable deterioration in facilities and equipment. Inadequate recurrent expenditures, obsolete drug therapies and outdated medical skills resulted in low quality of care and inefficient use of resources.

2. **Civil unrest and the Kosovo crisis took a heavy toll on the health care system during the 1990s.** The violence and civil unrest resulted in extensive damage to the health care infrastructure and in the disruption of essential services, including immunization, surveillance and environmental health programs, such as water quality and waste removal. Almost one third of the country's medical staff abandoned their posts during the 1997 unrest. The Kosovo crisis in 1999 put additional strains on the system, as over 4,000 refugees were admitted to hospitals, while others were provided accommodation in hospitals for want of other shelter. The crisis caused further damage, consumed a significant amount of resources and brought to a halt nascent structural reforms in the sector.

3. **A series of sectoral reforms were initiated in the mid-1990s, but limited progress has been made over the past five years in advancing these reforms.** While focusing on re-establishing services following the events of the early and mid-1990s, Government also initiated a series of reforms to begin to address some of the sector's weaknesses in the mid-1990s. The reforms included some reduction in the overextended provider network capacity, the decentralization of primary care management to district public health directorates and integration of the former with public health functions, the privatization of the pharmaceutical sector and most dental care, and the establishment of the Health Insurance Institute (HII) in view of a gradual aspired change of the health financing system. Plans were also made to substantially upgrade the quality of the primary care system through physical investments and skills upgrading. These initiatives were interrupted and limited progress has been made in most of the reform areas. Some pilot projects on the provider organization and financing front were initiated over the past four years which have yielded valuable lessons. More recently, encouraging progress has been made on pharmaceutical policy issues.

2. HEALTH OUTCOMES AND HEALTH CHALLENGES

4. **Despite progress achieved, Albania's health outcomes lag behind those of other countries in the South East European Region.** While all sources show an improvement in key health outcome indicators over the past decade, different data sources paint a different picture as to how well Albania is faring compared to other countries in the region**.** By most accounts, Albania's health outcomes compare relatively favorably to those of other lower middle income countries outside the Europe and Central Asia (ECA) Region, but not to other lower middle income countries in the South East European (SEE) Region. On the basis of official data, Albania enjoys the longest life expectancy in the Balkans -- just two years below the EU average. Other sources put Albania's life expectancy below that of all other countries in the SEE Region, and eight years below the EU average. Albania has the lowest healthy life expectancy in the SEE Region. Similarly, estimated data, which correct for expected underreporting, put Albania behind other countries in SEE regarding infant mortality.

5. **Albania's demographic and epidemiological profile is changing. The relative burden of infectious diseases is decreasing while non-communicable diseases have become the leading cause of death among the adult population.** Infectious diseases are still a leading cause of infant and child deaths, but they are no longer a major cause of mortality among adults. Although HIV/AIDS prevalence is reportedly still low, the risk of HIV transmission is high owing to mobility of the population and human and drug trafficking. Non-communicable diseases, mainly cardiovascular diseases and cancer, have become the leading cause of death among adults. The incidence of these diseases is expected to increase substantially as the population over 65 years of age doubles in the next 20 years. Some studies suggest that the diabetes incidence rate is higher than in many Western European countries and likely to grow substantially over the coming two decades. Among the top new health risk factors are the high tobacco consumption, the rapidly increasing rate of fatal road accidents and changing diets. The health care system is ill prepared to face the increase of non-communicable diseases and the lengthy and costly treatment associated with them.

6. **Albania's health care system is ill prepared to face the growing incidence of non-communicable diseases and other new health risks.** A significant portion of chronic disease conditions could be prevented through the promotion of healthy lifestyles, screening and primary and secondary preventive care measures. Increased focus on preventive health care is therefore becoming a pressing need in Albania. The capacity for health promotion and for primary and secondary prevention for cardiovascular diseases and cancer requires significant strengthening. This will require aggressive efforts to build up the capacity of primary care providers to adequately assess patient risk factors and to effectively manage the conditions of those exhibiting such risks. Concerted efforts are also required to improve Albania's health promotion capacity, so as to inform the population about new health risk factors and ways to avert them. Addressing these factors requires inter-sectoral coordination and outreach to the local community, in addition to the strengthening of the surveillance system. The Institute of Public Health is well placed to play a leading role in these efforts, but its capacity will require further strengthening and the resources allocated to public health issues, including health promotion and new public health initiatives, as well as health information, will need to be increased to allow to effectively address these issues.

3. HEALTH CARE DELIVERY

7. **A review of the distribution of physical and human resource capacity in the health sector points to large variations in coverage across districts and regions**. The significant internal and out-migration in Albania over the past 15 years, combined with the massive destruction of facilities during the 1990s, has left an already imbalanced health care provider network further out of line with the population's health needs. The distribution of physical and human resource capacity in the sector remains uneven across regions, as well as within regions. While substantial efforts have gone into rehabilitating primary care facilities following the widespread destruction during the early and mid-1990s, these efforts appear to have been made without any thorough analysis of population needs and the suitability of proposed facilities in a given area. Similarly, investments in hospital facilities continue to be made without a clear hospital map in mind, often leading to opportunistic investment decisions which contribute little to much needed consolidation and efficiency improvements in the sector.

8. **There are marked regional imbalances in medical personnel coverage**. Regional variations are highest for specialists and pharmacists and lowest, though still considerable, for primary care physicians. The relatively lower variation in general practitioner coverage appears to reflect concerted Government efforts to rebalance the ratio of general practitioners versus specialists, to substantially upgrade salaries for general practitioners, and, most importantly, to allow for considerably higher salaries for general practitioners serving in the more remote rural areas. There are also imbalances in terms of hospital versus primary care medical staff, and the ratio of doctors to nurses is high by international standards. There is considerable scope for substituting nursing time for physician time and clerical staff for nursing staff in hospitals in the medium to longer term. The skewed geographic distribution of health sector staff will need to be corrected over time as part of an overall planning exercise for health sector human resources.

9. **Productivity is low, both for primary and hospital care, and it varies substantially across regions and individual facilities.** Administrative data suggest that Albanians have

significantly less outpatient contracts with health care provides than people from other countries in Eastern Europe and Central Asia, Latin American and the Caribbean or Western Europe. Due to low perceived quality, bypassing of primary care in favor of seeking care at polyclinics or hospital outpatient facilities is widespread even for simple conditions like a cold or a flue. This leads to low utilization of primary care facilities and extremely low productivity of primary care staff. On average, a primary care doctor sees only about eight patients per day, with marked regional variations resulting in as few as three visits per day in certain regions. Analysis of primary care activity in Tirana region further points to substantial inter-facility variation in productivity. The gatekeeper role that general practitioners (GPs) are expected to play is not functioning, even though the MOH has introduced a fee system which would require payment for care by all those who seek outpatient care directly at a polyclinic or at the hospital. The fee structure, however, is such that it provides the estimated 60% of the population without a health insurance card with little incentive to see a primary care physician, particularly if it is felt that the physician will be unable to provide the expected care. Experience in other transition countries and initial evidence from recent pilot activities in Albania suggest that productivity of primary care providers, particularly in rural areas, can substantially improve if they are provided the with skills upgrading to offer a more comprehensive population centered set of services and have access to adequate supplies and equipment.

Table 1 - Distribution of Hospitals and Utilization, by Number of Beds, 2003

Bed range	MOH Hospitals		Beds		Admissions		Bed occup rate	ALOS
	Total	In %	Total	In %	Total	In %		
< 49 beds	11	23.9%	331	3.7%	5,392	2.0%	26.7%	6.7
50 – 99	9	19.6%	728	8.0%	16,000	6.0%	34.5%	5.6
100 -199	10	21.7%	1,386	15.3%	44,438	16.5%	47.8%	5.9
200 - 299	7	15.2%	1,774	19.6%	59,064	22.0%	67.5%	35.8 (*)
300 - 399	3	6.5%	1,072	11.8%	27,331	10.2%	53.5%	76.0 (*)
400 - 499	3	6.5%	1,236	13.7%	37,232	13.9%	39.0%	4.8
500 - 599	2	4.3%	1,099	12.1%	27,459	10.2%	48.3%	7.3
1000+	1	2.2%	1,423	15.7%	51,609	19.2%	74.4%	7.5
Total	**46**	**100%**	**9,049**	**100%**	**268,525**	**100%**	**53.6%**	**6.7**

Source: Ministry of Health Albania. Albania Health Indicators for Years 1993-2003. Note: (*) includes psychiatric hospitals with each having ALOS of more than 100 days

10. **A large number of small hospitals with low utilization and occupancy rates point to a sub-optimal hospital structure.** While low compared to European averages, Albania's hospital capacity (3.03 beds per 1,000 population) compares favorably to that of many other lower middle income countries and is similar to that of Spain and Turkey. However, the configuration of the hospital network points to large inefficiencies. Over 60% of Albania's hospitals are too small to exploit scale economies in the general acute care hospital setting. 30 out of 46 hospitals have less than 200 beds and jointly account for only one quarter of all hospital admissions, while they continue to consume a considerable amount of scarce resources. Low admission and occupancy rates lead to high staff per occupied bed ratios in the smaller hospitals and raise serious concerns about fixed costs, ineffective utilization of limited resources and quality assurance. Several hospitals exhibit an oversupply of identical departments that could be merged, thus allowing for substantial efficiency gains. Hospital managers have neither incentives nor authority to undertake changes to improve the efficiency and quality of their operation.

11. **The quality of health care is low, particularly at the primary care level.** The substantial amount of primary care bypassing and qualitative surveys point to serious deficiencies in the quality of care, particularly at the primary care level. Quality of care standards and standard treatment protocols have not been developed and adopted for outpatient care and providers do not have an established system for continuous quality improvement. The current incentive framework for providers gives no importance to quality of care. Quality issues identified by focus group participants and other surveys include low skills of medical staff, the lack of drugs, supplies and equipment, poor infrastructure, limited scope of services provided at PHC facilities, and the level of quality being conditional upon the informal amount a patient is willing to pay. Household survey data suggest that bypassing of primary care is more prevalent among the rural population and low income groups, although seeking care at a higher end facility results in higher out-of-pocket payments and longer travel times. This suggests that

the quality and scope of service delivery in primary care facilities in rural and peri-urban areas with a high concentration of poor households is of particularly concern.

12. **A recent survey on reproductive health found that the quality and coverage of prenatal care is of serious concern and ranks among the lowest in the ECA Region.** The survey found that while officially reported coverage of prenatal care is high, one in five women who gave birth between 1997 and 2002 did not have any prenatal care. This is one of the highest ratios in the ECA Region, and is similar to Central Asia. The survey also showed that 70% of pre-natal care provided was inadequate and that only one in five women had any postnatal follow-up. Although regional data on infant mortality are of questionable reliability, there are indications that mortality rates are higher in the poorest mountainous regions. Improvements in the quality of prenatal and obstetrical care will need to be given higher priority, particularly in the more disadvantaged regions, if Albania strives to move closer towards European averages for maternal and child health outcomes

13. **Health personnel in Albania continue to remain isolated and lack in-service training to upgrade their skills.** At the same time, they are often over-specialized for the type of population centered medicine needed to ensure that people can obtain comprehensive service at the primary care level. The limited efforts to strengthen clinical skills of primary care providers to date have been uncoordinated and dispersed. Albania's primary care physician and nurses have insufficient knowledge about the prevention, detection and management of non communicable diseases and of other growing health risks such as HIV/AIDs. There is also a need to carefully review and determine the scope of services which primary care providers can offer and ensure improved management of patient pathways.

14. **Quality improvement is a core objective of the Government's long term health sector strategy[24].** Albania has already undertaken substantial work on the establishment of quality standards for hospitals and strives to establish a hospital accreditation system. A set of quality standards covering the main domains of hospital functioning are currently being pilot tested. However, before a final decision on the appropriate mechanism to ensure quality control in the Albanian context is taken, it should be further assessed whether the financial and human resource capacity to support an accreditation system are available. Introduction of a quality improvement system will require a multi-pronged approach involving facilities managers, designated facilities staff, external surveyors and the health insurance institute as the agency which will purchase health services. It will also require awareness raising about the importance of continuous quality improvement among the medical profession as well as the wider population. Efforts at establishing and implementing standards will need to be complemented by skills upgrading of health care professionals.

15. **Although the private sector is still relatively small, its importance in providing outpatient services is growing.** Dental care and the pharmaceutical sector are largely privatized. The provision of other health care is still dominated by public providers, but the importance of the private sector is growing in the areas of diagnostics and outpatient services. While public sector physicians and nurses are not allowed to operate in private practice, (with the exception of university professors), anecdotal evidence suggests that the incidence of private care provided by publicly employed physicians may be growing. 2004 household survey data found that somewhat over 10% of those who sought outpatient care did so from a private provider, although official statistics point to only 626 private outpatient doctor's offices and 907 licensed private physicians, compared to over 2,100 public outpatient facilities with over 10,000 medical staff. As the economy grows and the health system develops, private providers will invariably become more important players. The Government's long term health sector strategy foresees that much of primary care would in the medium to long term be provided through independent primary care physicians or groups of independent physicians. Yet, an adequate regulatory framework and effective system of safety and quality regulation and inspection have not yet been developed.

16. **Substantial steps have been taken to improve transparency along the pharmaceuticals distribution chain and to institute cost containment on HII reimbursed prescription drugs and hospital drugs**. A new drugs law, enacted in 2005, simplifies the

[24] Government of Albania, Long Term Strategy for the Development of the Albanian Health System, July 2004. This document is referred to as the long term health sector strategy in this note.

registration of new drugs but raises the bar in terms of quality standards, requiring approval in a major foreign market before a drug can be marketed in Albania. Local manufacturers have to adhere to European standards for Good Manufacturing Practice within two years. Irregularities in the distribution network are being addressed by a sticker system for legally marketed drugs. Competitive tendering for hospital drugs has resulted in substantial cost savings and problems in the distribution to hospitals have been addressed through contracting with a private distributor, cutting back theft and diversion and leading to significant savings. Price negotiations for innovative drugs reimbursed by HII, an internal reference pricing system for generic drugs and informal budgets for prescribing physicians have been introduced to contain the rapidly increasing expenditures on prescription drugs. Remaining challenges include the need for further cost containment as the HII beneficiary population expands, the need to strengthen quality control in the market, the need for increased transparency of various commissions that make decisions affecting the pharmaceutical market and the need to further review the margins on drugs to encourage consolidation of a fragmented wholesaling and distribution system.

4. FINANCING HEALTH CARE

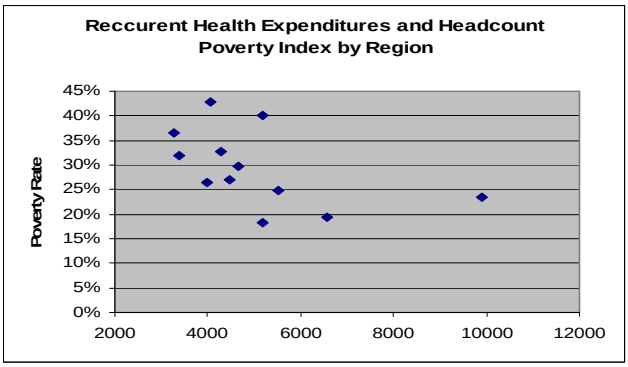
17. **The 6% of GDP which Albania spends on health care is in line with the average for lower middle income countries, but Albania's public sector contributes a below average share to these expenditures.** As a result of low public sector spending, out of pocket expenditures at the point of service account for almost 60% of sectoral funding. The high level of direct household spending signifies that the existing health financing system offers limited protection for the population against catastrophic illness or injury and allows for little redistribution of resources to protect the most vulnerable groups from health shocks. Although health insurance is mandatory, household survey data suggest that only between 40-45% of the population do in deed have a health insurance license and thus benefit from coverage. As is to be expected in a country with a large informal labor market, the coverage is significantly higher among the urban population and the upper income groups. Active contributors account for less than one third of the active labor force, pointing to large contribution evasion.

18. **The high share of out of pocket payments at the point of service and outside an overall health finance framework creates serious inequities in access, has a considerable poverty impact and limits effectiveness of the Government's sectoral stewardship**. Lower income households exhibit a significantly higher likelihood of incurring catastrophic health care expenditures than better off households, with the average out of pocket expenditures for one episode of outpatient care amounting to 50% of the average monthly per capita expenditure of the lowest consumption quintile. Although the law provides for free inpatient care, survey data suggests that essentially everybody who is hospitalized incurs substantial costs and that informal payments account for at least one quarter of these costs. Average outlays for hospital care amount to four times the monthly per capita expenditure of the lowest consumption quintile. The likelihood of paying for health care and the absolute amounts paid are lowest in Tirana and highest in the mountainous regions, pointing towards inequities which are of particular concern given the high incidence of poverty in those regions. Household survey data suggests that income and insurance coverage are important determinants of seeking health care, despite the fact that insurance benefits are limited to primary care and drugs benefits only.

19. **The continued fragmentation of the health finance system and at times unclear assignment of financing responsibilities have resulted in a lack of accountability for sectoral performance in general and individual providers' performance in particular.** The health finance system is fragmented with the MOH paying for hospital care, non-physician salaries and at times other operating costs for primary care, while HII pays for salaries of primary care physicians, prescription drugs and high end diagnostics. Financing responsibilities have changed repeatedly over the past several years, with local governments at times expected to cover operating costs for primary care. As a result of dispersed funding sources, the lines of accountability are unclear, particularly at primary care level. The introduction of user fees for outpatient care for those not covered by health insurance or those who circumvent primary care has not been applied evenly and tended to create uncertainty among providers and patients, leaving ample room for abuse. While informal payments are relatively modest for outpatient care, they are widespread and substantial for inpatient care. Input based financing gives providers no incentive to improve quality or efficiency and has led to skewed geographic allocation of resources. The geographic imbalance in the provider network and human resource base, combined with uneven access to

health insurance, have resulted in highly unequal distribution of public sector expenditure for health care, with regions with the highest poverty incidence generally receiving the least amount of public expenditure on health per capita as demonstrated in figure 1 below.

Figure 1 – Recurrent Health Care Expenditures and Headcount Poverty Index by Region



5. IMPROVING THE HEALTH SECTOR'S ABILITY TO MEET THE POPULATION'S CHANGING HEALTH NEEDS

20. **To consolidate achievements in health outcomes, establish capacity to effectively address new health needs and better protect low income groups from health risks, fundamental and systemic changes in the way health care is financed, delivered and organized will be required**. These can best be summarized around three core pillars: (i) more efficient resource mobilization and allocation; (ii) improvements in service delivery quality; (iii) improvements in sectoral management and stewardship.

21. **Pool all public sector resources under one funding agency.** To improve efficiency in resource mobilization and allocation and ensure maximum accountability of the funding agency and providers, all public sector resources, meaning budgetary funds and health insurance funds, should be pooled and channeled through one agency (the Health Insurance Institute) which will then purchase health care on behalf of Albania's population from health care providers. Pre-conditions for successful expansion of a payroll tax based social insurance system are not met in Albania. Preconditions include a large formal labor market, strong administrative capacity for contribution collection, good regulatory and oversight structures and strong economic growth. If these conditions are not met, and they rarely are in middle income countries, payroll tax based social insurance results in substantial inequity in access to health care, a problem which Albania is already beginning to face.

22. **Rely on general taxation rather than payroll tax contributions as the main source of public funding for health care.** This note recommends that Albania consider phasing out the current 3.4% payroll tax contribution for health insurance and shift entirely to general taxation as a public source of funding health care, fiscal space permitting. Currently, only 7% of public sector spending on health come from non-budgetary contributions to HII, this amounts to only 0.2% of GDP and could be absorbed by the general budget over the next few years. A second best solution would be to maintain, but not increase, the current health insurance contribution rate, pool contributions with general revenues under the Health Insurance Institute (HII) and introduce a two tiered benefits package. However, this solution would administratively prove substantially more demanding. In view of HII's limited administrative capacity, it would appear more prudent to focus on building up HII's capacity on the purchasing side and rely exclusively on a general revenue financed system in the years to come.

23. **Clearly define the health care benefits which will be made available from public funds and introduce co-payments for a wider range of services, including inpatient care.** The amount of public sector funding for health care will invariably remain limited. To increase transparency, enhance provider accountability and improve equity in access, it is necessary to clearly spell out what services the population is entitled to receive free of charge from public providers, what services will require a co-payment from the patient and for what services the population must pay in full. The limited amount of public sector resources available in the medium term will require that co-payments for most care be

substantial and some high end procedures be excluded from public funding. In view of the currently low consumption of primary care and its potential cost effectiveness, co-payments for such care should remain relatively low, while substantially higher co-payments could be introduced for higher order care, with hefty supplements for those who self-refer to higher order care. Protection mechanisms should be put in place to mitigate against the impact of the out-of-pocket payments for low income groups. This could take the form of co-payment limits for social assistance recipients or alternatively selected target groups using proxi-means indicators. The high poverty impact of out-of-pocket drugs expenditures suggests that low income groups should eventually be accorded limited drugs benefits. If funding is purely general revenue based, this would essentially mean that a single basic benefits package be introduced for all, with limits on co-payments and limited drugs benefits for low income groups and possible drugs benefits for other target groups. If the funding remains two tiered (e.g. general revenues, plus payroll tax based contribution) general revenues would provide for a basic package for all, with expanded benefits for low income groups commensurate to those received by HII contributors.

24. **Combine the introduction of increased co-payments with broad based action to root out informal payments.** Informal payments create a substantial burden on those who seek care, both financially and through the uncertainty which they create. Furthermore, these funds remain completely outside the managerial control of the health system. The objective of introducing broader co-payments would be to formalize these payments, rather than to increase the already high out of pocket payments. Therefore the introduction of wider formal co-payments must be combined with aggressive efforts to curb informal payments, through public awareness raising campaigns, allowing providers to allocate a substantial amount of co-payments collected towards performance based salary supplements, introduction of patient complaint mechanisms and prosecution of gross violators. Evidence from other countries suggests that combining such efforts with the introduction of formal co-payments does allow for reduction in informal payments. In the medium term, further revisions to the medical staff remuneration system will also be required, but these could be undertaken within the overall framework of changes to provider payments. Given the prevalence of informal payments in hospitals, it is advisable that efforts first focus on reducing informal payments there.

25. **Increase resource allocation for public health and health information.** The health care system remains skewed towards clinical care, while public health initiatives remain underdeveloped and under funded. The increasing burden of non-communicable diseases and the new health risk factors call for increased emphasis on health promotion and public health initiatives. Furthermore, the analysis of epidemiological trends in Albania is severely compromised by the availability and reliability of data. Incomplete and inadequate data can not form the basis of effective policy. It poses the risk of distorted emphasis and attention. This is an area which has not received sufficient attention over the past. The Institute of Public Health (IPH) has a good basis and would be a natural body to assume responsibility for the collection and analysis of routine health information as well as increased focused research efforts. Similarly, IPH has a good basis and would be the natural locus for increased efforts in health promotion and public health initiatives. However, IPH can only effectively carry out these tasks if more resources are allocated towards health promotion, new public health initiatives and health information and its capacity is further strengthened.

26. **In the medium term, shift to a population based regional allocation of health sector funds.** The current system of allocating funds merely based on existing infrastructure and human resources results in inequitable allocation of resources and gives health care providers no incentive to improve performance and efficiency. Therefore, as Albania introduces changes in the way providers will be financed and further streamlines the provider network, it may want to move toward a system where resources are allocated regionally on a risk adjusted capitation basis, with adjustment factors taking account of demographic and socio-economic factors.

27. **In the medium term, improve the balance between public and private spending on health care to enhance the population's protection from health shocks.** Albania spends about 6% of GDP on health care. While this is less than most ECA countries spend, it is about on par with the average for lower middle income countries. However, Albania's share of public sector spending in total sectoral spending (38%) is below the average of lower middle income countries (45%) and substantially below the average of upper middle income countries (58%). Over time, Albania may wish to improve the balance between public and private funding, by gradually increasing the share of public funding. An increase in the share of public funding could be linked to the expansion of the publicly provided benefits

package. The high share of private out-of-pocket funding creates serious inequities in access, has a considerable poverty impact and limits the effectiveness of the Government's sectoral stewardship. However, any increase in public funding should be closely linked to fundamental reforms in the way resources are allocated and utilized.

28. **Finalize and use the hospital map as an instrument to guide any future investment in the hospital infrastructure.** The large number of small hospitals with low utilization rates and poor physical conditions, overall low hospital occupancy rates and the continued indecisiveness about which hospitals should expand their capacity to serve as regional hospitals call for a careful evaluation of the country's hospital infrastructure. In view of the substantial remaining investment needs in the hospital sector, there is a critical need to finalize the hospital map based on efficiency, quality assurance and accessibility considerations and then utilize this map to guide further investments in the sector. While the poor quality of the road network may not allow for highest optimization of the hospital network in the medium term, there is nevertheless a need to consolidate those facilities which are rarely utilized, but continue to consume a substantial amount of resources. Options to better organize the multiple departments with the same profile across a relatively small catchment area or at times even within the same hospital should also be explored. The decision to establish a regional hospital that would provide a substantial range of services in each of the 12 regional prefectures also deserves further consideration, in view of Albania's limited resources to maintaining such a network.

29. **Develop regional primary health care plans.** The overall low but largely varying productivity of primary care providers calls for an evaluation of current PHC planning standards and the revision of the scope of services which GPs and PHC facilities can provide.

30. **Improvements in service delivery will require action on four fronts:** (i) upgrading the clinical effectiveness, (ii) changing the incentive framework for providers and, (iii) establishing a quality assurance system and, (iv) further consolidating reforms in the pharmaceutical sector.

31. **Consolidate pilot efforts to improve clinical effectiveness and quality of care.** Pilot efforts to develop clinical guidelines, to train primary care providers in their use and to introduce quality improvement and case management processes at provider level, appear to have yielded promising results, as demonstrated by lower bypass rates and an increase in visits to concerned primary care facilities. These efforts should now be taken a step further by institutionalizing the development and adoption of treatment and prescribing guidelines, establishing a national in-service training program for physicians and nurses and developing and implementing a training program. The latter could initially focus on providing primary care staff with the skills necessary to better meet the population's demand for health care. While there clearly also is a need to improve the skills of outpatient specialist and hospital physicians, the substantial amount of primary care bypassing and the need to strengthen capacity for health promotion and primary and secondary prevention for non-communicable diseases make skills improvement at the primary care level a first priority. However, efforts to strengthen the clinical skills of providers are unlikely to reap the desired results unless they are accompanied by changes in the incentive system.

32. **Shift from input based financing of health care providers to performance based payments.** Under the current input based financing system providers have no incentives to increase efficiency and improve quality and quantity of care. It is therefore suggested that the payments for providers be changed to a performance based system by means of having HII contract with providers for a defined bundle of services. Experience in other transition economies as well as OECD countries suggests that capitation based payments (with possible performance supplements) for primary care and global budgets with case mix adjusters may present a good basis for such changes in Albania. It would, however, be critical that capitation payments (or a variant theory) for primary care include the full cost of providing care (including operating costs and allowance for equipment depreciation) and be based on actual enrollment of patients with a particular doctor or facility. The development of global budgets for hospital providers would need to occur gradually. The introduction of case mix adjusters would be conditional upon provider information systems becoming more developed so that they can provide the necessary data on the financial and clinical performance of facilities and, ultimately, of facility departments. Work in this respect could build on the achievements to date at Durres hospital. However, such changes can only be expected to lead to desired provider behavioral changes if they are

complemented by organizational changes which give providers increased managerial autonomy and by efforts to strengthen the quality of care.

33. **Establish a quality assurance system.** Ongoing efforts to establish hospital quality standards should continue, in parallel with the development of quality standards for primary care. Standards should cover clinical care, administrative and financial services, as well as facilities and equipment. The feasibility of establishing an accreditation system deserves further review on fiscal sustainability grounds. As a first priority, the provider licensing system would benefit from substantial strengthening so that it can serve as an instrument to ensure higher quality of care. This would require development of new licensing standards and development of capacity in MOH to enforce these standards. Physician licenses could be rendered more meaningful if they were subject to periodic renewal (re-licensing) conditional upon completion of continuing education requirements.

34. **Consolidate reforms in the pharmaceutical sector.** The possible expansion of drugs benefits to a wider population group, together with stricter registration requirements for generic drugs, are likely to put additional pressure on drug expenditures. Steps will therefore need to be taken to ensure cost containment. This will require keeping a close watch on prescription patterns, reviewing the co-payments structure and co-payment exemption policy, tightening the positive list of reimbursable drugs and introducing an indication reference group based reimbursement system for innovative drugs. A review of the positive drugs list and co-payment policies could take place within the framework of the overall definition of the publicly financed benefits package. In the medium term, the structure and level of margins for distributors and pharmacists deserve further review. Current margins are relatively high and do not encourage consolidation of the fragmented distribution system. The composition and modus operandi of the main commissions dealing with registration, reimbursement of drugs and licensing of professionals would benefit from further review to rule out conflict of interest and to increase the transparency of their decision making. The capacity for quality assurance needs to be strengthened to avert wide spread perception of the low quality of many generic drugs. In the absence of local laboratory capacity, this service could be contracted from a qualified international laboratory, but a rigorous system of random sampling at customs and in retail pharmacies, combined with public information about potential quality violations and decisive action against violators will need to be established.

35. **The roles and responsibilities of all core actors in the sector need to be clearly defined and accountability mechanisms established.** Accountability in Albania's health sector is weak due to unclear definition of responsibilities, lack of proper performance standards and monitoring tools and insufficient integration of feedback from stakeholders into policy formulation and decision making. The Government's long term health sector strategy and the reforms proposed here entail substantial changes in the roles and responsibilities of various actors in the sector. The MOH would assume a policy making and stewardship role and increasingly withdraw from service provision and financing of health care. The HII would assume full responsibility for financing of health care, channeling the Government's health budget to health care providers by contracting them to offer a defined set of services to the population against an established price. Service providers would be given increased autonomy to decide how to most effectively produce these services and their performance would be evaluated against an established set of performance standards. These changes require a supportive legislative framework, establishment of performance standards and monitoring tools and most of all a clear definition of each actor's functions and responsibilities. They would also require substantial stakeholder consultation to ensure broad based support for the proposed changes and adequate capacity building at MOH, HII and provider level.

36. **The potential role of regional health authorities needs to be reviewed in light of the pilot experience gained in Tirana and a decision needs to be made about the future of regional health authorities in Albania**. The Tirana Regional Health Authority (TRHA) was established in the Tirana region as a pilot experiment with the objective to consolidate previously dispersed public health, health planning and health management functions under one umbrella and optimize service delivery in the Tirana region. The experiment did not reach its expected results for a variety of reasons. The effectiveness of RHAs stems mainly from their ability to allocate the available funding amongst service providers in a region and make the necessary trade-offs to improve the overall quality and access to patient care. This, however, requires that RHAs be granted full autonomy to make such decisions and calls for highly skilled managerial talent to prepare for, propose and subsequently execute such decisions. The experience in Tirana suggests that the required skills may be difficult to find

in Albania, and that there is a continuous danger that MOH retains decision rights, thus obviating potential benefits of RHAs. If these conditions are not met, it is unlikely that the benefits of the RHA approach outweigh the costs in terms of an additional layer of management and decision-making, and especially in terms of the use of scarce managerial talent. This would suggest that the direct purchasing model, whereby HII would contract individual providers or groups of providers directly may be a more appropriate solution to consider for Albania and that the further expansion of RHAs should be carefully revisited. Therefore, it is recommended that the Government commission an external evaluation of the TRHA pilot as a basis for a decision about the role of RHAs in Albania in general and TRHA in particular. TRHA was conceived as a pilot and therefore calls for careful evaluation and corrective action based on the evaluation results.

37. **Organization and Management of Primary Care Providers.** The Government's long term health sector strategy envisages that primary care will eventually be provided through independently contracted general practitioners or groups of such practitioners. While this is the model which many ECA countries have adopted, it would be important to carefully evaluate the feasibility of such arrangements for primary care provided in rural areas. Alternative set-ups to consider for rural areas might be community based health organizations or affiliation of rural health care providers with urban providers under an umbrella contract with HII. To this effect stakeholder consultations with providers in rural areas might be carried out and the feasibility of various organizational arrangements in the Albanian context further evaluated.

38. **Increasing autonomy for hospitals.** The Government's long term health sector strategy and proposed amendments to the hospital law foresee that hospital providers will become autonomous non-budgetary not for profit public organizations governed by a board, while the MOH will retain the right to appoint the hospital director. This points to inherent conflict between granting providers increased autonomy under the governance of their boards and MOH's reluctance to withdraw from service delivery. It also points to a need to further evaluate the proposed governance structures for autonomous hospitals. Increasing autonomy of hospitals will require substantial capacity building both of hospital managers and of the governing board members and important decisions will need to be taken about the extent of autonomy which such institutions will be granted. In the medium term, granting hospitals full autonomy, including over decisions of the desired profile, scope of services to be provided and large investments is not advisable in the Albanian context. Similarly, it is not advisable in the medium term to grant hospitals full financial autonomy to the extent of letting them borrow commercially for investments. On the other hand, as provider management capacity increases, providers could be granted increased autonomy over human and financial resource allocation within a given budget, including staffing positions and salaries, and they could be given the right to decide on the utilization of potential savings achieved under HII contracts.

39. **Population Feedback and Community Participation.** To date, both community participation in the health sector and seeking direct feedback from the population on sectoral performance have been largely neglected. Local authorities and community representatives can play an important role in ensuring accountability of providers through, for example, representation on provider governing boards and through participation in local or national sectoral performance reviews. To the extent that the reforms will be implemented gradually on a regional basis, the Government may wish to institute regular stakeholder consultations and sectoral performance discussions with the involvement of sectoral and community representatives. Sectoral performance targets for the region could be established, monitoring mechanisms agreed upon and outcomes subsequently reviewed on a regular basis. Targets could include provider performance indicators, health outcomes, and the extent of financial protection of low income groups. Similarly, feedback mechanisms from users of health services, particularly as the reforms begin to take hold, will be of critical importance to gauge the success of such reforms. In the short and medium run this would require specific efforts to gain such feedback through patient satisfaction surveys, possible report card systems as they have been introduced by Tirana Municipality, focus group discussions, provider utilization surveys and the establishments of patient complaint mechanisms. In the longer run, more organized feedback through patient right organizations or similar set-ups might take hold.

6. IMPLEMENTATION

40. **The changes in the organization and financing of health care will require a gradual introduction and careful preparation and capacity building of health care**

providers, HII, and MOH to ensure that they are ready to assume their increased responsibilities. Fundamental decisions on the legal status, organizational arrangements, governance structures and extent of autonomy for health care providers will need to be taken before such changes can be introduced. Provider accounting systems need to be strengthened, performance standards established and adequate provider reporting and information systems introduced to allow for appropriate performance monitoring and transparency. Provider management capacity will need to be developed and payment reforms will need to be coordinated with efforts to improve the quality of care to enhance payment mechanisms' incentives for behavioral change on the provider as well as the patients' side. Therefore, it is proposed that the Government consider implementing reforms in a phased approach. The first phase would be a preparatory phase which would involve deciding on provider organization and governance structures, developing appropriate accountability and reporting mechanisms, developing and costing out the benefits package to be made available from public funding, enhancing the legislative framework to support the changes, and establish training programs in provider management and clinical skills upgrading. The second phase would introduce changes in provider organization and financing in two regions in parallel with upgrading of clinical and managerial skills, expanding on going initiatives in Durres and one of the regions where USAID support has been paving the ground for improved provider performance management and clinical upgrading. Based on results from the second phase, the initiative could be expanded to three or four additional regions and finally during a subsequent phase to the remaining regions. In parallel, the capacity of IPH to assume increased responsibilities in health promotion, health information and health intelligence and new public health initiatives would strengthened to ensure that it can assume these important new functions effectively.

ANNEX D

SUMMARY OF USAID PROGRAMS

1. **Improving Primary Health Care**
2. **Albania Family Planning Program**

ANNEX D.1

IMPROVING PRIMARY HEALTH CARE

(*PROShëndetit*/PROHealth)

Implemented by University Research Corporation with Bearing Point and American Association of Family Physicians

The PRO Shëndetit project uses the mission's SO for primary health care services and the three intermediate results – improving health systems, enhancing quality, and increasing the utilization of services – as its own results framework. Major project activities that lead to the achievement of the intermediate results are briefly presented in the following pages. Activities proceed in each targeted region based on the speed with which the project and the ministry of health can progress and upon possible complementary project activities that are being initiated in the area. A map is included for one region showing how three different major activities are beginning to cover the region: quality improvement at health sites, community-based health promotion, and the introduction of the new health management information system. Program activities will expand to cover this and other targeted regions as rapidly as the program and its partners can do so, with

In order to successively implement program activities the project follows two important guiding principles. First, e*stablish, strengthen, and utilize local human-resource networks;* this is a conscious, sought after goal. It is important to identify and strengthen local human-resource networks that can undertake development efforts; success in developing vibrant networks is necessary for sustainability. The network effort can be seen in PRO Shëndetit's work with the Faculty of Medicine that in turn is developing a network of general practitioner trainers in each prefecture.

When economic resources are scarce and existing official human resources meager, it is essential to identify or form and develop local human-resource networks that can undertake the necessary human inputs for achieving better health. The process is an essential foundation block of sustainability.

The second guiding principle is to work hard at f*orming linkages between existing systems and the human-resource networks*. When resources are scare it is a natural reaction to protect and maintain what ever meager resources are available within any operating unit, e.g., health district, hospital, community, and family. Units do not naturally look outside themselves to link with other units when resource expenditures appear likely. PRO Shëndetit works at linking systems and units that together can make greater impacts on health than if they operate separately. For example, the formal health system is linked to the community through engaging members of the formal system to team with (link with) members within the community. It is important for the official health system to define the community as a resource for better health and not merely as consumers of services. Network development and making linkages between systems and networks are themes that can be seen throughout PRO Shëndetit's work.

The major activities described in the following pages are: health information system development; health finance system development; community-based activities; overall approach to quality; COPE as a quality tool at service delivery sights; monitoring and evaluation, and some general changes in behavior that have been documented.

New Health Information Management System in Albania[25]

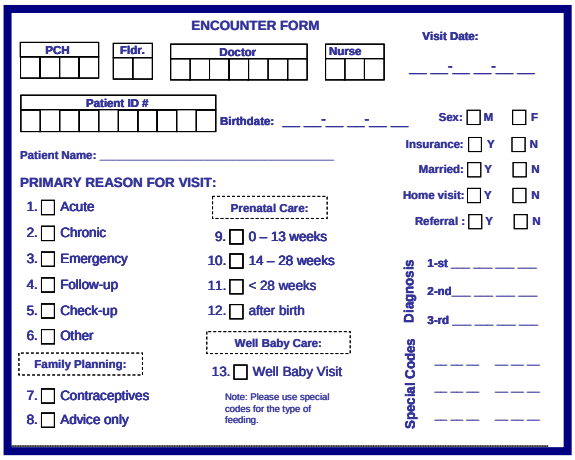
Albania, like countries the world over, has kept track of medical events in registration books. The system works fairly well; it is still used in almost all resource-poor countries. A major problem with the system of registries is that it is extremely labor intensive in making reports, analyzing diagnoses, and treatments and then providing feedback to the providers that originally recorded the data.

The picture on the left is from a current registry book being used in Albania. It records the clients for each day, the health professional that sees them, and the treatment received.

Over the past two decades, much of the world has moved to systems that are electronically managed; systems permitting quick summations, reporting, analysis, and provide the potential for useful feedback. In short, such systems make evidenced-based medicine achievable, even in resource-poor countries.

The ministry of health worked with a USAID funded project in Berat to establish an electronic system in four pilot health centers. It worked well and the MOH requested PRO Shëndetit to assist in rolling-out the system nation-wide.

At the base of the new health management information system (HMIS) is the encounter form, shown on the right. Each and every contact a health provider has with a client, from measles shots to treatments of hypertension and diabetes, is recorded on an encounter form.


ENCOUNTER FORM

PCH | Fldr. | Doctor | Nurse | Visit Date: __ __-__ __-__ __

Patient ID # | Birthdate: __ __-__ __-__ __ | Sex: M F

Patient Name: _____ | Insurance: Y N | Married: Y N | Home visit: Y N | Referral: Y N

PRIMARY REASON FOR VISIT:

1. Acute
2. Chronic
3. Emergency
4. Follow-up
5. Check-up
6. Other

Family Planning:
7. Contraceptives
8. Advice only

Prenatal Care:
9. 0 – 13 weeks
10. 14 – 28 weeks
11. < 28 weeks
12. after birth

Well Baby Care:
13. Well Baby Visit

Note: Please use special codes for the type of feeding.

Diagnosis: 1-st ___ ___ ___ | 2-nd ___ ___ ___ | 3-rd ___ ___ ___

Special Codes: ___ ___ ___ ___ | ___ ___ ___ ___ | ___ ___ ___ ___

Standard international codes for diagnoses are used and reported in the blanks assigned to "diagnosis." It can also be seen in the lower right of the form that there is room for special codes. One example might be that the health center is having special community health campaigns and the particular client had come to the health center due to a campaign; it would be recorded so a measure of campaign effectiveness could be determined.

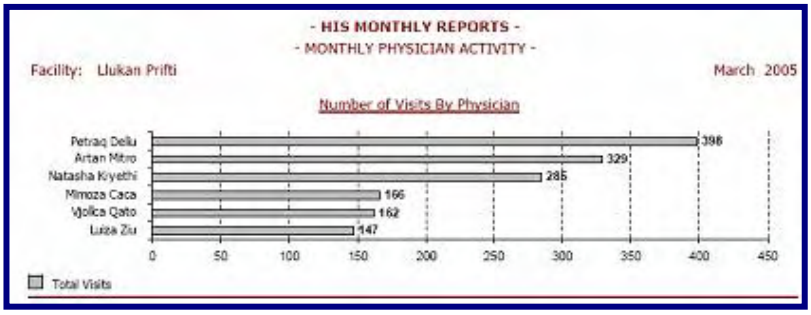
The MOH and PRO Shëndetit are convinced that the form should be simple to begin with. Once a system is established, the MOH can begin to make appropriate adjustments and grow a system to accommodate its needs. Currently, an estimated 52 per cent of all client contacts are taking place at health posts in PRO Shëndetit's five initial-focus prefectures.
Although the percent of clients attended to by all nurses and midwives from their homes (included here as "health-posts") is not currently known, those operating from their homes do make up approximately 56 percent of the 979 health posts in the five initial-focus prefectures.

[25] Reference this document as PRO Shendetit, "Two-pager: New Health Management Information System in Albania."

The picture on the left is of a nurse in Berat, at her home that serves as a health post. She had just brought her encounter forms to be checked to see if they were being filled correctly, when the program first began. Initially, the form needs to be something that can easily be filled any where the health system is operating.

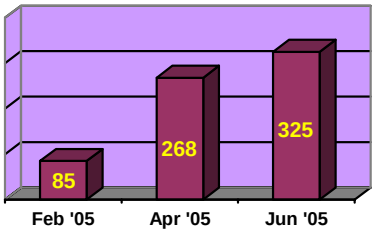
Already MOH, Health Insurance Institute (HII), and PRO Shëndetit are looking for ways to make the form more useful. For example, once HII becomes the single-payer for primary health care and contracting with health centers takes place, there will be a need to assess performance and quality.

The head nurse of the health center collects the forms from all providers, including those at health posts and delivers them to the health information system regional office – a data entry and management office in each prefecture. The office is comprised of a system administrator and six or seven data entry persons. The computer system is bilingual with Albanian and English interfaces and reports. It is widely regarded as simple and user-friendly.



Feedback is crucial to the improvement of primary health care and is an area where the MOH and PRO Shëndetit will place considerable effort over the coming year. The simple, but comprehensive structure of the collected information allows for a large variety of reports to be generated. On the right is a simple report showing the total number of clients met by five different physicians working in one health center in Berat during the month of March

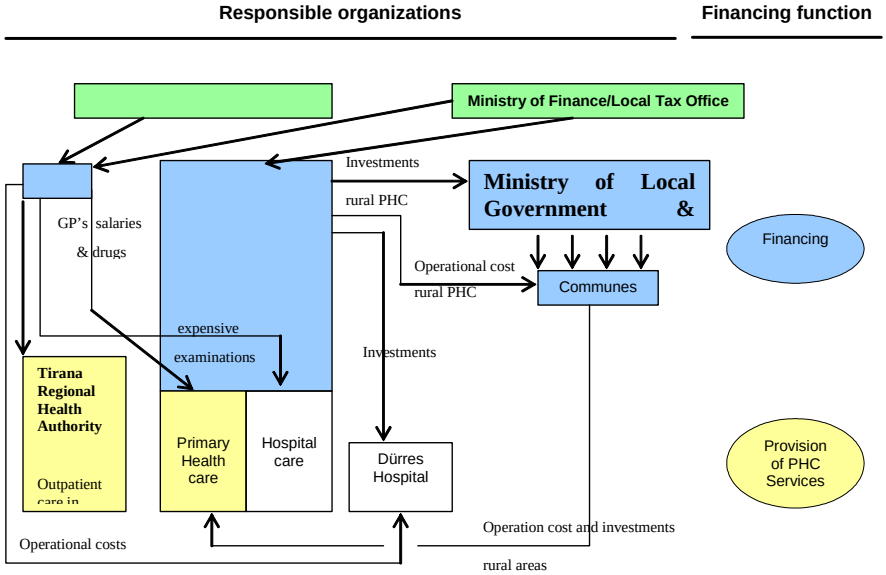
The roll-out of the new HMIS began by including all service delivery points in the Berat prefecture (268). This system was reporting by the end of April. Two pilot health centers and their associated health posts (57 service delivery points all together) were added, staffs trained, and were reporting by the end of June. The total numbers of service delivery points using the new HMIS are shown in the bar graph on the left. By the end of PRO Shëndetit's annual reporting period (July), 121 physicians and 666 nurses and midwives had been trained to use the encounter forms. The MOH and PRO Shëndetit will continue the roll-out in the rest of the initial five prefectures during 2005, and will begin taking the system to other prefectures in 2006.



PRO Shëndetit's Health Financing Activities[26]

Albania was brought to the edge of bankruptcy and civil war during the late 1990s; this drained the country of both financial and intellectual resources. Only 2.8 per cent of GDP currently goes to health services in the public sector (the European Union average is 8 per cent). The depletion of resources plus small investments of existing resources has left primary health care outdated – sixty-four per cent of health centers in the Tirana region (the national capital) are without water, poorly equipped and only two per cent of expenditures are used directly for diagnoses and treatment.

The primary health care system is managed centrally, with little incentive or capacity for health centers to rationalize and focus to achieve efficient use of scarce resources; there is little to no focus on performance and outcomes. The fragmented system of financing health care, and specifically in this instance primary health care, does not favor cost containment, transparency, or accountability. Four administrative bodies are involved in fund raising (Ministry of Finance, Local Tax Offices, Social Insurance Institute and Health Insurance Institute) and three bodies are funding different parts of the system (see the blue portion of the following figure) and without a single body responsible for pooling[27]. As is clear from the figure, there are many players in the system. At present, the roles, responsibilities, and linkages between the players is far from clear.



In close collaboration with other donors in the health sector, PRO Shëndetit is supporting three core objectives of the MOH long-term health strategy for health financing: 1) implementation of single-source financing, 2) autonomy of providers, and 3) the introduction of performance contracts.

Single-source financing means that a single organization, the Health Insurance Institute (HII), will be responsible for payment of health-care providers. It will act as the single pooler of resources (see the blue portion of the preceding figure). Payment will be based on a contract between HII and health centers. This process will increase transparency as it introduces a relationship between resource allocation and performance, as well as a system for monitoring services delivered. Within PRO Shëndetit, there is close collaboration between the service

[26] Reference this document as PRO Shendetit, "Two-pager: PRO Shendetit's Health Financing Activities."

[27] *Pooling of funds* refers to institutions that receive public funds and either *procure/purchase* services from independent providers or cover the cost of providing services through their directly managed units for health *provision*.

provision team, working to enhance site and individual performance, and the health information team, that will assist in reporting health services and indicators of the quality of those services.

Autonomy of Providers (AP) means that health centers will have the right and means to decide how to organize the provision of services to best meet the needs of the local population. The result of AP will be providers organized according to medical professionalism, attuned to the different population groups (age and gender groups –all such data are included in the new HMIS) and to varying regional needs. The AP couples rights and obligations with incentives to provide more and better quality services.

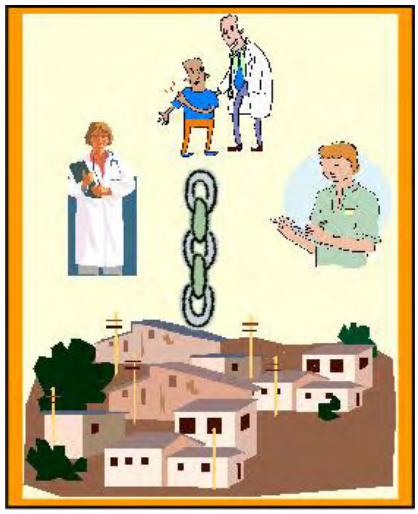
Berat is the proposed site where the new health financing program will begin. This is because of the efforts already made in Berat by the MOH and USAID, i.e., the development and operation of a region-wide functional health management information system,[28] skill improvement activities for general practitioners and nurses, and training of health officials and providers in understanding the new plans for financing primary health care.

The introduction of the new health financing system in Berat is a major objective of PRO Shëndetit. However, the path towards achieving this objective is neither smooth nor straight. Single-source financing is not possible without HII being able to plan available amounts of resources and successfully anticipate the future. Contracting is not possible before HII and health center physicians possess capacity to negotiate, conclude, and follow-up on contract implementation. Autonomy of providers is not possible before physicians have capacity to plan and manage performance. These stepping stones are what the Health Financing Team is now laying along the pathway to health reform. The status of the implementation is listed below.

Status of implementation	Major implementation steps
►	• ***Determine a set of performance improvement indicators that reflect productivity, data accuracy and the quality of clinical care by the PHC teams.*** • ***Develop the new contract to be signed between the HII and the PHIs.*** • ***Elaborate budget for 2005 for the primary health care institutions in Berat*** • Elaborate rules and procedures for audit of performance • Simulation-Contracts to be concluded for year one. • From year one each PHI receives a monthly statement from HII, showing what it would have been paid if the new contract has been in force • Reflection of the new payment system in the budget law • From year two each PHI receives an *actual* payment equal to the amount simulated under the new integrated payment system. • Regulations defining the autonomy of the PHIs. • Establish financial management capacity in each PHI • Year two, the PHIs in Berat have setup their own bank accounts, have trained financial managers/accountants, and have working accounting systems and financial procedures in place. • Define a benefit packaged of services, to be delivered by the PHIs, • Define the role and the responsibilities of the Regional Health Authorities. • Define the standards and norms according to which HII can conclude contracts with the PHIs.

[28] This was initially developed as a pilot in four health centers by USAID's PHRplus project.

Health Promotion



There are two general thrusts of PRO Shëndetit's work in health promotion: the first is to increase general awareness of health issues and primary health care benefits. The main target audiences are men and women, with messages on topics such as reproductive health, HIV/AIDS, and TB. In addition, these target audiences play important roles as primary care givers and suppliers of knowledge to their families. The second thrust is to have people within communities become more aware of health options and their own capabilities to influence good health - to become active participants. One of the anticipated outcomes of health promotion activities is an increased demand for, and use of, primary health care services. Health promotion is an essential part of the demand-side engine that drives improvement in primary health care.

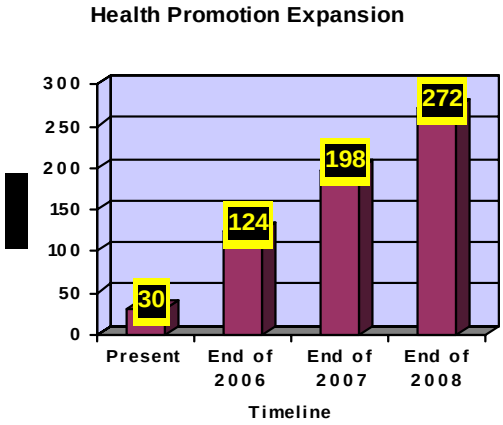
In order to improve primary health care in Albania, it is essential to build strong linkages between communities and primary health-care providers. Communities have to become participants in the better-health process

There are 374 communes in Albania; it is a huge challenge to build the essential linkages in these communes while continuing to operate within a resource-poor environment. The Ministry of Health and PRO Shëndetit are doing this in the following ways:

There is little-to-no government budget for health promotion within districts, but there are MOH staffs assigned to health promotion. These staffs are playing important roles with PRO Shëndetit in helping to build the necessary linkages between communities and the more formal health system. Selected staff members undergo a TOT course, as shown in the picture on the left, and, in turn, become trainers of community health-promotion teams. These teams are composed of both local health professionals and motivated community members who believe in the importance of health promotion, and who are committed to helping health improve. The majority of these community-based volunteers are teachers.

As shown in the picture on the right, manuals, teaching aids, and tote bags have been developed for the community health promotion teams to use in villages where they work. PRO Shëndetit currently has community teams working with villages in Lezhe, Shkoder, and Korca. During 2006, almost all communes will be covered in PRO Shëndetit's five initial prefectures (in Diber, it is the Red Cross that is doing community-based work through its USAID child-survival project). Also, during 2006, activities will begin in four other prefectures – Gjirokaster, Vlore, Fier and Elbasan.

Eight percent of the communes in Albania are currently covered within the scope of community-based health promotion activities (30 communes). By the end of 2006, 33 per cent of Albania's communes will be included in the program and 70 percent by the end of 2008. The numbers associated with this increase are shown in the bar graph on the right.



The human-resource network – health professionals and community members – is the backbone of community-based efforts.
Working with this system, PRO Shëndetit will assist with motivation, assure appropriate message presentations, develop and add additional messages, and at the same time expand the system. Developing and expanding the network is the largest program challenge for PRO Shëndetit's health promotion program. The development of messages and materials are essential and are time consuming elements of a good health promotion program. Nevertheless, the motor that makes it all run – now, and in the future for sustainability – is the human-resource network.

Some of the health promotion team's work is interwoven with the work of other PRO Shëndetit teams.

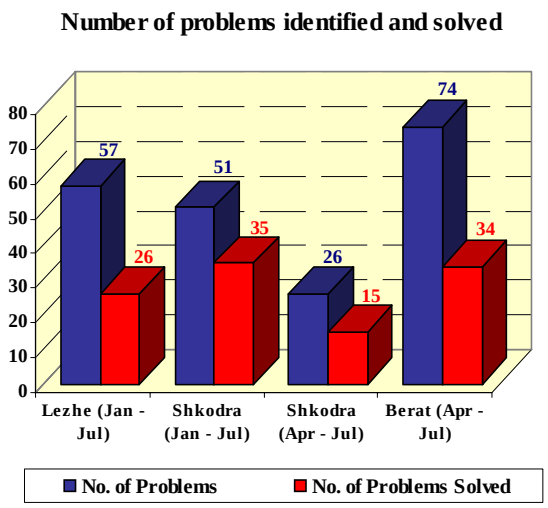
- During 2006, the health promotion team will work with MOH, HII, and the health finance team with an information campaign. Technical assistance in health communication will be provided to assist in developing community-focused campaigns to help people better understand the health insurance system – their rights, obligations, and options. It is one of the MOH and PRO Shëndetit efforts to ensure that Albanians understand their options and are enabled to make informed choices regarding their health.
- Also during 2006, the health team will work closely with the MOH and the service delivery team to improve the information and training that service providers receive in health promotion.
    - A health promotion component will be developed for the program the MOH and PRO Shëndetit are using to train general practitioners. This will be developed in collaboration with the MOH and Health Promotion unit in the Institute of Public Health.
    - In addition, the continuing medical education program that the MOH has initiated, with PRO Shëndetit assistance, for nurses and midwives requires the development of health promotion information and training materials.

Health promotion for PRO Shëndetit is clearly two-pronged. It is essential to insure that the public is well informed about health, and that it is enabled to make informed choices about options that are available to them. At the same time, it is important that service providers become more sensitive to the importance of their roles in health promotion, and committed to working with and engaging people in their communities.

Quality Improvement – from Multiple Directions[29]

Quality improvement in primary health care is advanced by PRO Shëndetit through improvements from four directions: 1) A program to improve primary health care at service-delivery sites through inexpensive, largely self-help team efforts; 2) there is a program to improve the knowledge, skill, and performance of doctors, nurses, and midwives; 3) a supportive system of facilitative supervision and coaching is being developed to support improvement in performance; and 4) programs are underway that are assisting with having physicians achieve certification as family doctors and health centers recognized through accreditation.

Improvement of services at site of delivery is a primary goal. Whether clients go to a health center, a health post, the home of a nurse in their village, or are visited at their own homes, quality services should be available. The Client Oriented Provider Efficient (COPE) quality improvement (QI) tool is being used to improve the quality of services at delivery sites. Health center teams determine the needs to improve quality of services; they identify the problems curtailing better services. These problems become the focus of the team, and an action plan is written on a white board on the wall. Assignments are made among staff members with regular follow-up, as the program becomes part of the health system. The tool is a simple, low-cost, team-building approach; it is an initial step toward quality improvement. An indication of progress is shown in the accompanying figure. The bars show the number of problems identified at the beginning of the QI process for 43 health centers and the number of problems solved by July.



Performance improvement is the human-resource objective of PRO Shëndetit; training is one step in performance improvement. There are two main training programs developed by the ministry of health and PRO Shëndetit. The first concentrates on improving the skills of general practitioners (GPs). The faculty of medicine has a team currently developing trainers from among the most promising physicians in each prefecture. The prefecture teams will then undertake the training of all GPs in the prefecture in 30 modules. The American Academy of Family Physicians is providing part of the training of the prefecture teams. Completion of this program moves general practitioners part way through a program that will certify them as family physicians. This training program will include seven prefectures by 2006. There is also a continuing medical education (CME) program for nurses and midwives. This program is conducted by district hospital specialists and other skilled district health trainers. CME topics are determined by a CME board in each district. Examples of topics being addressed through the early part of 2006 include high blood pressure and diabetes; STD/HIV/AIDS; immunization febrile convulsions/high fever; family planning, child growth and development; antenatal care and pregnancy; cancer screening of breast, cervical, and skin; and care for chronic patients –TB DOTS. The program began in Berat in 2005; it will expand to all five of the initial-focus prefectures in 2006 and the rest of Albania by 2008.

[29] Reference this document as PRO Shendetit, "Two-pager: Quality Improvement – from Multiple Directions."

Facilitative supervision, coaching, and auditing standards are important for performance improvement of GPs, nurses, and midwives. PRO Shëndetit and the ministry of health are providing training in facilitative supervision and coaching as opposed to using traditional check lists. In addition, an experienced auditor of clinical procedures is conducting performance audits of GPs that are participating in the 30 module program. Facilitative supervision and coaching training will be conducted by district health officers and doctors that have undergone TOT for the 30 module program. These activities began in 2005, will expand to the five initial-focus prefectures in 2006, and to the rest of Albania in 2007 and 2008.

Policies and guidelines play crucial roles in improving and sustaining quality in health care. PRO Shëndetit is supporting the ministry in its effort to establish a certification program for general practitioners and an accreditation program for health centers. The effort in certification will be a program to move general practitioners towards certification as family physicians. There are currently 1,500 general practitioners with an additional 210 graduated each year. At the same time, the Faculty of Medicine is able to graduate only 12 family physicians a year. A cumulative point program is being developed that will assist general practitioners to accumulate points towards certification. The proposed program has a limit of ten years, after which time all family physicians will have to be trained in the specialty of family medicine at the Faculty of Medicine, or at other recognized training institutions. A ministerial decree has set up the task force to work on defining and implementing the certification process.

When health centers undertake quality improvement and have staff involved in performance improvement programs, these will count toward health center accreditation. PRO Shëndetit works closely with the Health Insurance Institute (HII) as well as the ministry of health. HII is to become the single source purchaser of health services. By both the HII and MOH working together, contracts established with health centers can be made to reward staff at centers that have become accredited, i.e., providing a monetary incentive to achieve and maintain accreditation status.

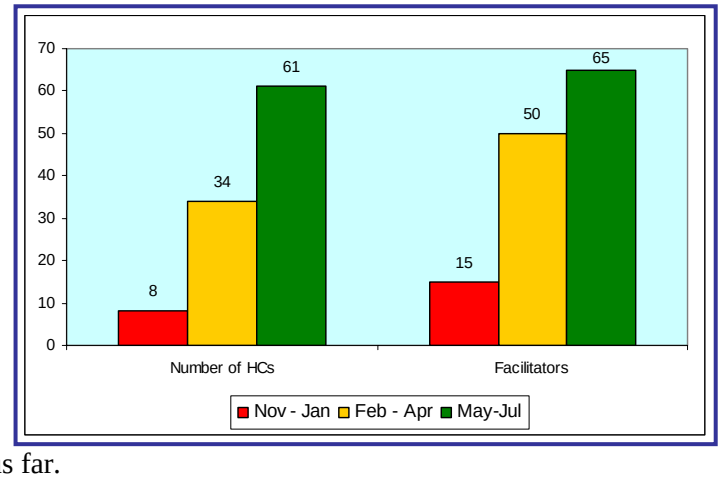
Quality improvement is being achieved from multiple directions: delivery sites, individual's performance, supportive supervision and coaching, and policies and guidelines to assist in creating sustainability. The USAID primary health care program is fortunate in working with both the Ministry of Health and the Health Insurance Institute. Delivery site improvement in performance, knowledge and skill enhancement of staff, coupled with policies and guidelines attached to a system of monetary rewards for maintaining quality, provides the potential for sustained quality improvement in primary health care.

Quality Improvement at Health Centers and Health Posts[30]

The Health System in Albania has 688 health centers and 1,779 health posts, for, a total of 2,467 service delivery sites. However, health posts operated from nurses' homes are not counted in the published figures. There are well over 2,500 health posts, plus health centers, almost all of which are in varying degrees of need for quality improvement – many in great need. A quality improvement tool for these service sites was chosen that is client-oriented, relatively simple to implement, does not require resources unlikely to be available in the near future, and can easily be built upon with other quality enhancing tools. *COPE*®[31] is the quality improvement tool selected.

In January 2005 the Ministry of Health and its Quality Improvement Board approved *COPE* for nation-wide use at health centers and health posts in Albania; in December eight persons were selected and trained to be the core facilitators in the national roll-out of *COPE;* and translation of the manual was completed in January 2005.

Expansion of this part of the general QI program takes place through district-level workshops where : 1) officials from the MOH introduce the program and stress MOH's support; 2) district health officials are introduced to the QI tool by the core facilitators (see above picture) and taught to be facilitators in introducing the tool at health center level; 3) health center staffs identify quality gaps and make action plans – as the one shown on the left from Vau Dejes health center in Shkoder; 4) periodic staff meetings review the process and make adjustments where necessary; and 5) *COPE* becomes part of a health center's routine activity and is incorporated into the district supervisory system, with quarterly data collection, evaluation, and feedback

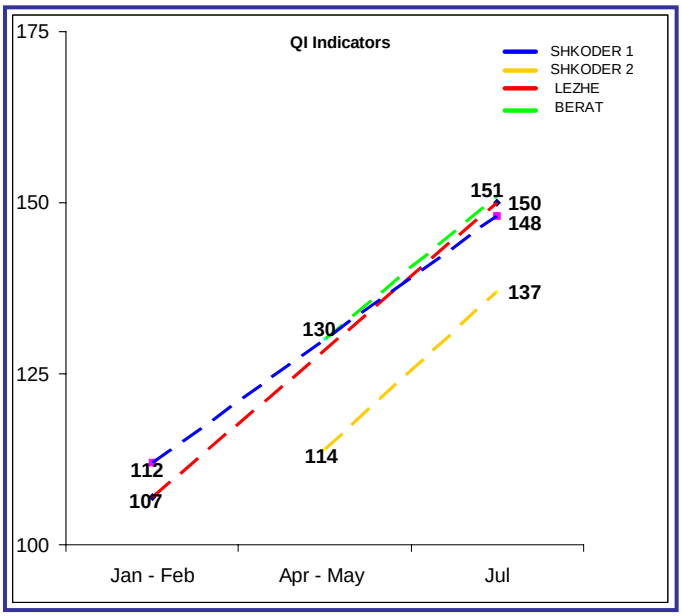


District level training began in the Lezhe district for 14 health officers in January. Since then, the program has continued to grow rapidly. The graph on the right shows the cumulative number of health centers engaged in the QI process at the end of July 2005 and the number of facilitators that have been trained. A total of 61 health centers and 199 health posts for a total of 260 service delivery sites are engaged in the QI program. There are 856 service providers trained in the program thus far.

[30] Reference this document as PRO Shendetit "Two-pager: Quality Improvement at Health Centers and Health Posts"

[31] COPE is a name copyrighted by EngenderHealth; the acronym letters stand for "client oriented and provider efficient." Like many acronyms, COPE has come to be a widely recognized name as an acronym.

A recent July assessment was made of a 50 per cent sample of program health centers to judge progress. The assessment revealed that there is a long way to go in achieving the level of quality improvement expected from the health delivery system in Albania; nevertheless progress is evident.



One of the tools for assessing progress is 40 indicators of general health center quality. For example, health centers are checked to see if there is a duty roster for night and weekends, regular staff meetings are being held, there are posters in the waiting area, and leaflets are present for clients. Since each indicator is measured along a five point scale, a maximum score of 200 is possible. The health centers assessed in July was grouped both by district and the time they entered the QI process; HCs began either in January-February or April-May. The lines in the graph on the right show the average scores at the start and in July. As might be imagined, there was considerable variation among health centers, and, in one case, a health center's score actually decreased. Overall, however, quality improvement appears to be underway. It can be seen that there is upward movement in the average QI scores for all groups.

At this introduction-stage, *COPE* is focused on overall management and team-work at the health center level. The second-stage will focus on the quality of service delivery through application of guidelines and protocols. A peer review system will be initiated to help develop and strengthen the facilitative-supervision and coaching system of the MOH.

Example of typical make-do arrangements at health centers

Some problems are beyond the ability of health center staffs to solve, e.g., major infrastructure and funding issues. PRO Shëndetit is collaborating with the MOH to identify and clarify areas where outside resources are necessary. Some resources are expected from a Japanese funded World Bank grant to Albania, and some will come from government budget allocations.

However, some minimal equipment is necessary now, to assist providers in offering quality services; consequently, PRO Shëndetit is working with the MOH to provide a minimum-package of equipment to health centers that demonstrate a commitment to providing quality services.

At the end of 2006, the introduction-stage of the quality improvement program will be active in four additional prefectures: Gjirokaster, Elbasan, Fier and Vlora (in addition to Shkoder, Diber, Lezhe, Berat and Korca). The quality improvement program will then include parts of nine prefectures and be operational at over 200 health centers.

Monitoring and Evaluation[32]

PRO Shëndetit monitors and evaluates its performance by tracking a set of 28 indicators on a near monthly basis. This is accomplished through using routine activity reporting information. Additional information is collected, as necessary, by conducting periodic rapid assessments, and population-based surveys. The routine information is reported to the monitoring and evaluation officer who maintains a data base for easy access of information.

The following table shows a selection of key indicators updated at the beginning of September. There are three indicators at the strategic objective level and two indicators for each of the intermediate results. The indicators in the table are part of the annual report to USAID. Other indicators, not shown here, are used in project management and for helping PRO Shëndetit staff members assess their work and make changes as appropriate.

*Preliminary un-weighted data from Lezha prefecture

Objectives and Indicators	Baseline 04	Target 05	Actual 05	Target 06
SO 3.2: Improved Selected Health Care Services in Target Areas				
Percent of SPDs providing integrated PHC services	<5	None set	24	40
Modern method contraceptive use	8%	None set	15%*	12%
Abortion rate	341	None set	397*	350
IR 1: Health resources efficiently managed				
Initiation of single source financing in at least one prefecture	No	No	No	Yes
Percent of health centers using encounter forms regularly	4	33	9	40
IR 2: Quality of PHC services improved				
Percent SDP providers trained/refreshed in PHC	<1	20	4.3	30
Certification guidelines written for family physicians	No	No	No	Yes
IR 3: Use of PHC services increased				
Percent communities conducting health promotion activities	0	5	4	15
Health service utilization rate[33]	66	None set	248	275

The five initial-focus provinces of PRO Shëndetit are darkly shaded in the map on the right. In 2006, expansion will take place into four additional prefectures. The names of the new prefectures are shown on the map. Since most project activities will expand to cover all of Albania, the denominators used in calculating indicators (unless stated otherwise) are national level data. In the preceding table, for example, the denominators for determining percent of health centers using encounter forms regularly, or the percent of communities conducting health promotion activities, were all-health-centers and all- communities in Albania.

Using sub samples for geographic specific areas from the national Reproductive and Health Survey is one way that the project is able to produce indicators from past points in time. Additional information for Berat prefecture came from the PHRplus project and for Diber prefecture from the American Red Cross child survival project. For the three prefectures for which there were no current survey data – Shkodra, Lezha and Korça – PRO Shëndetit conducted a population-based survey in August 2005. The sample included 1,200 married women of reproductive age and 499 men

[32] Reference this document as, PRO Shendetit "Two-pager: Monitoring and Evaluation"
[33] The service utilization rate is the number of contacts at health posts and health centers per 100 population.

Data collection and entry for the August survey were done in the field by interviewers using hand-held ("pocket") computers. The use of hand-held computers reduced the time and effort needed for data entry, as well as reduced the possibility of interviewer error in data coding and skip patterns.

PRO Shëndetit also conducts rapid assessments and other types of surveys, as operational research to guide and check program activities. An early assessment was done to collect feedback about the progress of COPE[34] and a survey of health centers to determine minimal equipment needs. Further monitoring and evaluation work of this nature are ongoing regular activities of PRO Shëndetit.

[34] Implementation of a Quality Improvement Tool for Primary Health Care in Lezhë and Shkodër health centers: *An early assessment*

ANNEX D.2

DESCRIPTION OF ALBANIAN FAMILY PLANNING PROJECT (AFPP)

Implemented by John Snow, Inc with the Manoff Group

The Albanian Family Planning Project (AFPP) operates within a national Primary Health Care (PHC) framework established by the Ministry of Health to ensure universal access to primary care in Albania.

AFPP Goal: Work within the national PHC framework to expand access to quality family planning services in sixteen districts, and to increase awareness of modern family planning methods and availability of contraceptives nationwide.

AFPP Components:
1. Contraceptive Security -- assist the Ministry of Health achieve and maintain contraceptive security.

2. Family Planning Training -- complete FP training in the country's remaining 16 (of 36) districts

3. Behavior Change Communication -- increase knowledge of FP and promote the use of modern family planning methods.

COMPONENT 1: Contraceptive Security

Strategy: Use the existing National Contraceptive Security Commission for maintaining adequate contraceptive stocks in the country, and coordinating the contributions of the public, social marketing and commercial sectors to contraceptive security in Albania. Support the MOH Logistics Management Information System (LMIS) to ensure an uninterrupted supply of contraceptives to approximately 300 MOH service delivery points that provide FP services.

Expected Overall Result: Contraceptive security in Albania, i.e., the guaranteed long-term supply of quality contraceptives for every Albanian who wants them.

Key Indicators for Component 1

- Contraceptive Security Commission meets regularly under the leadership of the MOH Vice Minister, with representatives from the social marketing and commercial sectors.
- Timely and accurate LMIS data is generated by the MOH and used in decision making to ensure contraceptive security in Albania.

Strategies for Component 1

1. Ensure a continuous supply of contraceptives at health facilities nationwide, with special focus on availability in the sixteen target districts.
2. Strengthen the Contraceptive Security Commission by forming a small working group within the Commission to serve as a Secretariat.
3. Use the Bucharest RH Conference (April 2005) to 're-start' the Contraceptive Security Commission and provide a contraceptive security action agenda for AFPP.
4. Assist the MOH to streamline LMIS to make it more sustainable while providing all the core data required to maintain contraceptive security in Albania.
5. Integrate LMIS training into the FP training; include LMIS in the topics that the Master Trainers are qualified to teach.

6. Assist the MOH to synchronize the current LMIS with the emerging HMIS.
7. Leverage UNFPA resources to support contraceptive security in Albania, especially in contraceptive forecasting and LMIS (computers, printing forms, technical assistance.)

Results achieved in the first year of work

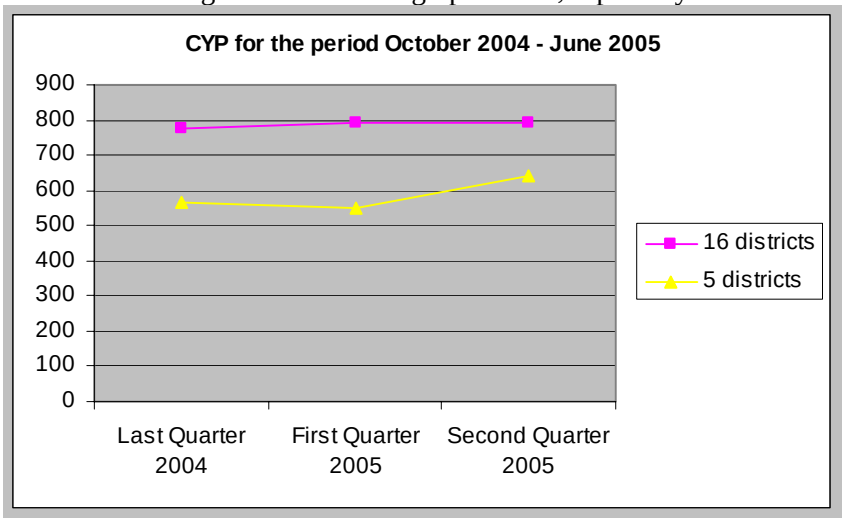
AFPP provided technical support to the MOH Logistics Management Information System (LMIS), reviewing the LMIS database and correcting software errors that were causing problems with processing LMIS reports. The table shows % of FP service delivery points reporting LMIS data.

% of FP service delivery points reporting LMIS data in Apr-June quarter 2005	In five (5) focus districts	97 %
	In sixteen (16) project districts	94 %
	In all FP SDPs in Albania	81 %

Contraceptive Stockouts. The data below show that stock outs are a chronic problem for the MOH. The stock out situation for the progesterone only pill (POP) is especially serious (the MOH failed to make a timely procurement request to their POP supplier UNFPA.) The stock out issue is an important agenda item for the Contraceptive Security Commission, but in the meantime, AFPP has assisted the MOH to take a number of practical steps to reduce stock outs, including shifting LMIS processing from the understaffed MOH to the Institute of Public Health that is already successfully handling vaccine logistics.

Stock Outs in 16 AFPP Districts								
							Target 2005	Target 2006
	Q1 2004	Q2 2004	Q3 2004	Q4 2004	Q1 2005	Q2 2005		
Low dose	14%	12%	9.6%	22%	14%	15.9%	20%	10%
Injectable	17%	8%	11.5%	14%	14%	18.2%	20%	10%
Condoms	23%	22%	15.4%	28%	32%	25 %	20%	10%
POP	26%	41%	52%	64%	52%	63.6%	20%	10%

CYP is increasing as shown in the graph below, especially in the five focus districts.



COMPONENT 2: Family Planning Training

Strategy: Form teams of local trainers and master trainers (MOH staff) who train providers in 16 target districts (170 service delivery points) in quality family planning services, including modern methods of contraception, contraceptive logistics management, counseling and community out-reach. Build upon the curriculum, cue cards, and trainers previously developed in Albania with JSI collaboration.

Expected Overall Result: By training FP providers in these remaining 16 districts, Albania will achieve nationwide FP service coverage by mid-2006.

Key Indicators for Component 2

- A minimum of one provider trained in family planning in 90% of 170 potential FP service delivery points (Maternities, Women's Consultation Rooms, Health Centers) in 16 target districts.
- Increase in the number of FP service delivery points in Albania from 300 to 430 by 2006.
- Couple Years of Protection (CYP) in the target districts doubles during the life of the project.

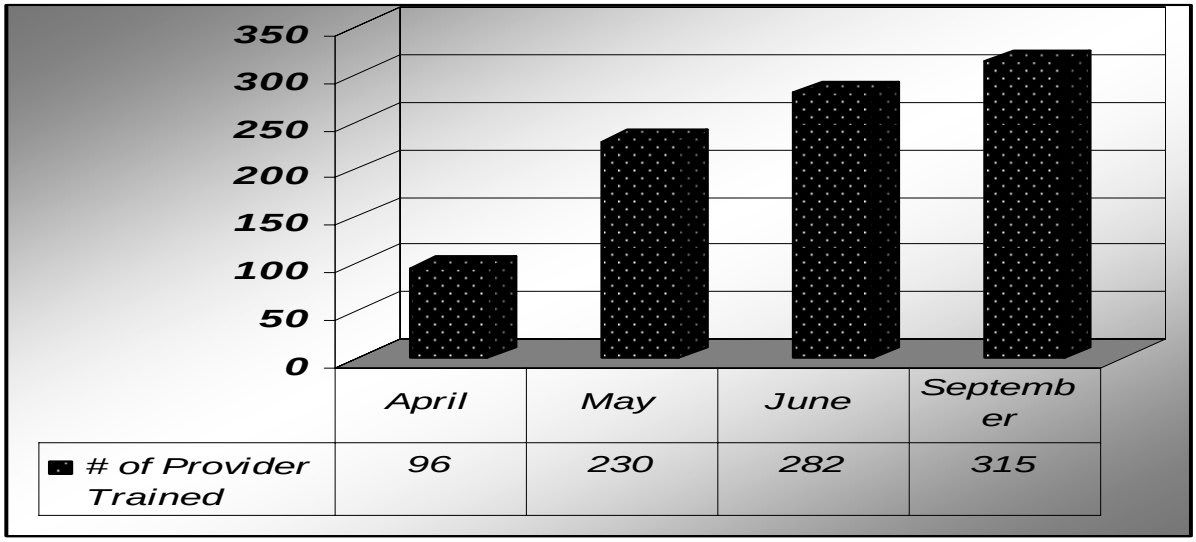
Strategies for Component 2

1. Begin FP training in the most populous of the 16 target districts for a greater impact early in the project.
2. Develop a National Family Planning curriculum & Trainer's Guide based on current international FP guidelines, effective counseling techniques, and informed choice.
3. Develop an indigenous, sustainable FP training capacity in Albania by forming a small cadre of Master Trainers within the MOH able to organize and implement trainings for district-level FP trainers throughout Albania.
4. Use local training teams composed of MOH staff to deliver FP training courses, thus building local training capacity and contributing to the long-term sustainability of FP training.
5. Use FP training to integrate the other two project components by including in all trainings 1) LMIS to ensure availability of contraceptives, and 2) BCC materials to create awareness and demand for family planning.
6. Include some community midwives in training sessions to increase community out-reach with FP information and services, and improve the linkage between community midwives and local health centers for support, supervision and LMIS reporting.
7. Coordinate FP trainings with ProShendetit to create synergy and maximize the use of resources.
8. Conduct follow-up visits to a sample of trainees to reinforce FP training through on-the-job support, provide the basis for supportive supervision by local officials, and assess training effectiveness.
9. Conduct exit interviews with a sample of clients to help assess quality of FP counseling.

Results achieved in the first year of work

Family planning training was conducted on schedule in five districts during the first year -- Lezha, Diber, Lushnje, Fier, Vlore and Puke – and this added 47 new FP service delivery points (SDPs) to the MOH system with 315 health providers trained in FP.

Total MOH Staff Trained in FP Through June 2005



First year training achievement is reflected in the PMP table below.

Indicator	Disaggregation	Baseline (Year)	Expected & Actual Achievements for the 1st year (Sept 2004–Sept 2005)		Target FY 2006
			Expected	Actual	
% of SDPs in 16 target districts with staff trained using national FP curriculum	**By type of SDP:**				
	Maternity	0 %	50 %	37.5 %	90 %
	WCR	0 %	50 %	50 %	90 %
	Health Center	0 %	50 %	55 %	90 %
	By cadre:				
	Doctors	0 %	50 %	64 %	90 %
	Nurses/ midwives	0 %	50 %	60 %	90 %

Training follow up, which began in September 2005, will reinforce knowledge and skills taught during the training (technical, counseling, LMIS), monitor the effectiveness of AFPP training, and allow for identifying problems so that they can be resolved. To help guide the follow up visits and provide standardized feedback to the project, facility providers and managers, and MoH (district and central levels) use "Integrated M&E tools".

COMPONENT 3: Behavior Change Communication Strategy

Strategy: Use mass media, print materials and community mobilization to increase awareness of the availability of family planning methods and services, to motivate people to seek these services, and to use safe, reliable family planning methods to achieve their goals for timing and limiting pregnancies. Create awareness and demand for FP services in the sixteen target districts, but also nationwide. Phase BCC activities into the sixteen districts in a synchronized way to create demand once the training component has assured that trained personnel are in place and that the contraceptive security component has assured a consistent supply of contraceptives.

Expected Overall Results: Increased social acceptability of using effective contraceptive methods and increased demand for and use of FP counseling/ methods.

Key Indicators for Component 3

- Couple Years of Protection (CYP) in the target districts doubles during the life of the project.
- Number of family planning visits in the target districts doubles during the life of the project.

Strategies for Component 3

1. Use social research-based methodologies and results of other studies to determine audiences, behaviors to promote (e.g., appropriate media and BCC messages.)
2. Identify and address barriers to/supports for changing key behaviors necessary to achieve increased use of modern methods.
3. Use mass media to broadcast FP messages and the location of FP services; re-enforce mass media messages with a variety of FP training and print materials (flip charts, brochures.)
4. Develop spots aimed at male and female married Albanians, segmented by rural and urban audiences
5. Insert a 'family planning message' or discussion into at least one popular TV program.
6. Get family planning information to Albanians nationally through a call-in show which features prominent, respected Albanian family planning experts (e.g., from the MOH)
7. Address potential barriers to increased contraceptive use in the community and increase community midwives technical awareness by providing FP awareness seminars at monthly district meetings of community midwives; these will be synchronized to precede the appearance of the FP actors and actresses in the district.
8. Contribute to community mobilization to support family planning by collaborating closely with the ProShendetit Project in developing BCC materials ,insuring the inclusion of community research findings in AFPP training, and developing a sustainable face-to-face communication pilot campaign in selected areas.
9. Promote the national FP logo in BCC campaigns and materials.

Results achieved in the first year of work

The primary BCC result to date is to have developed a BCC strategy and media plan that will be implemented during the second year of the project. The core of the BCC strategy are TV spots being prepared that are aimed at urban and rural couples. BCC interventions will be monitored to measure the impact on changing FP behavior.

Other Major AFPP Achievements To Date

Contraceptive Security

- AFPP and MOH officials participated in a major Contraceptive Security Conference in Bucharest in May 2005, which served to highlight the key contraceptive security (CS) issues in Albania and provide direction for AFPP technical assistance. In June, the project began data collection for a comprehensive SPARHCS study (Strategic Pathway to RH Commodity Security) that will be completed next quarter and provide a baseline for AFPP contraceptive security interventions.
- Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) data collection began in May; inputs being provided by the MOH, private sector, social marketing sector and other NGOs involved in contraceptive supply. Based on this the Contraceptive Security Strategy of the year 2003 was updated and the first draft was ready by the end of the first year.
- AFPP assisted districts with LMIS software problems, repaired MOH computers, and supported & trained the LMIS operator at MOH headquarters. AFPP assisted the MOH to decentralize the LMIS by training 10 districts in "Computerized LMIS at District Level."

Family Planning Training

- Revising the Family Planning curriculum, adapting/revising the PTT curriculum into a refresher training, selecting regular and master trainers, conducting TOTs, revising Cue Cards, and developing both a training data base and roll-out schedule provided the basis for conducting family planning training in the intervention districts, which will commence next quarter.
- Master trainers were also trained in skills needed to design, plan, implement and evaluate a training program. This is the first time a core of master trainers has been developed within the MOH, and should contribute significantly to the capability of the MOH to sustain and expand training in the future.
- Meetings and workshops were held with ProShendetit and American Red Cross to coordinate training schedules and share training materials for greater synergy, and two trainers from ARC were trained in the TOTs. In addition, AFPP worked with ProShendetit to develop a FP counseling flip chart and client pamphlets which are targeted for completion by June, and will be introduced during training sessions for providers to strengthen counseling on informed FP choice. The training strategy was refined and incorporated/integrated into the overall Project strategic framework & PMP during the Strategic Planning workshop.

Behavior Change Communication

- BCC Strategy Development Workshop was held. The BCC Strategy, based on AFPP and research, as well as the TIPs results, was presented and discussed with stakeholders. As a result, a final BCC strategy was developed, and then a Media Plan based on the strategy.
- The most effective behavior change communication (BCC) messages and types of interventions determined.
- BCC Survey Report produced.

Expected Achievements by the End of the Project in September 2006

1. Address the contraceptive funding shortfall in Albania; prepare a up-to-date forecast of the contraceptive commodities required by the government and social marketing programs over the next five years, and obtain financial commitments to cover these supply needs.

2. Re-vitalize the National Contraceptive Security Commission (it has not met in two years.) Mobilize stakeholder participation in the Commission, i.e., representatives from government, donor and international organizations, social marketing and the commercial sector. The NCSC needs to better articulate its mission and authority, and mutually agree on problem identification and problem solving procedures.
3. Determine the cause(s) of chronic contraceptive stock outs at MOH service delivery points, and take action to correct the problem.
4. Determine the type and level of donor assistance required over the next five years to maintain contraceptive security in Albania, and communicate these assistance needs to potential donors.
5. Mobilize increased government funding for reproductive health, thus reducing the current dependency on donors for the procurement, storage and distribution of contraceptives, for RH training, and for contraceptive logistics management. Strive to engage donors in ways that ensure short and medium term availability of contraceptives while simultaneously ensuring long-term contraceptive independence.
6. Increase demand for FP services through a mass media campaign that provides messages to inform Albanians about the advantages of modern FP methods, provides accurate information for decision making, and provides information about where to obtain quality FP services.
7. Integrate BCC survey findings into FP training in order to reinforce BCC messages at SDPs.
8. Focus BCC interventions on males and rural segments of the population, as well as women and urban populations.
9. Conduct follow-up and supportive supervisory visits to at least 33% of trained service providers to reinforce training and obtain data at the facility level regarding service provision.
10. Complete training of providers in the remaining 11 intervention districts.
11. Increase the level and reliability of LMIS reporting through training at district level, and developing trouble-shooting and data analysis capability at the central level.

Challenges and New Opportunities in the Future

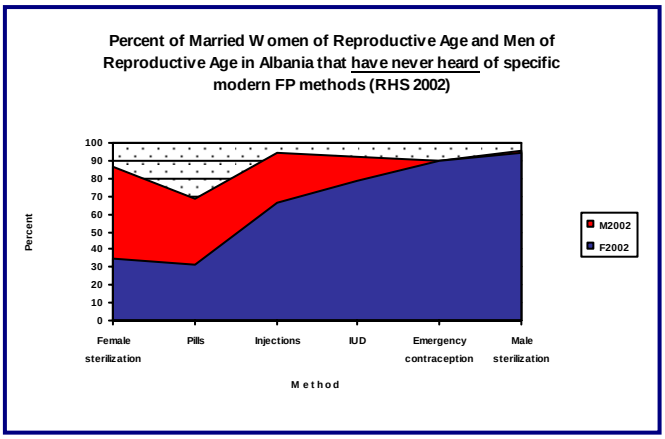
- Consistent and committed oversight of the FP program by the National Contraceptive Security Commission, especially with regard to having a sound strategy moving toward market segmentation and a changed method mix (less reliance on re-supply methods), a functional LMIS, procurement of commodities thru a mix of government and donor contributions with a gradual decrease of the latter, strategic coordination of the public, social marketing, and commercial sectors, and proactive support for the other components of a successful FP program (provider training and supportive supervision, demand creation/BCC.)
- An expanded BCC program with on-going mass media campaigns appropriate for both rural and urban audiences, reliable supply of up-to-date print materials, hot lines and call in programs, periodic surveys to make sure messages are meeting the need for information to make informed choices and decisions. Additional focus on appropriate messages for men will be important for a successful FP program.
- Training that includes a clinical component, especially for long-term and permanent methods. Training should be both pre-service and at regular intervals for in-service providers (possibly exploring innovative ways to provide updates such as web sites, distance learning, computer modules, etc)
- Provide timely follow-up after training and on-going supportive supervision at the district and facility levels.
- Increased community outreach, through increased utilization of community midwives as providers of FP services and information/counseling and utilizing

existing NGO networks; better utilization of nurses, midwives and rural family doctors at SDPs.

- Promote feedback from clients at SDPs (e.g. suggestion boxes, exit interviews, participation on quality improvement teams) to improve both quality in fact and quality in perception. As FP clients become better informed, will demand a higher level of service and a wider range of contraceptives.
- Maintain the strong regional technical links and lessons learned from JSI's and other RH health projects in the region (Ukraine, Russia, Georgia, Romania, CAR.)
- Develop strategies and expand services to reduce the large unmet need for contraception; perhaps set a target of reducing unmet need by 50% over the next three years.

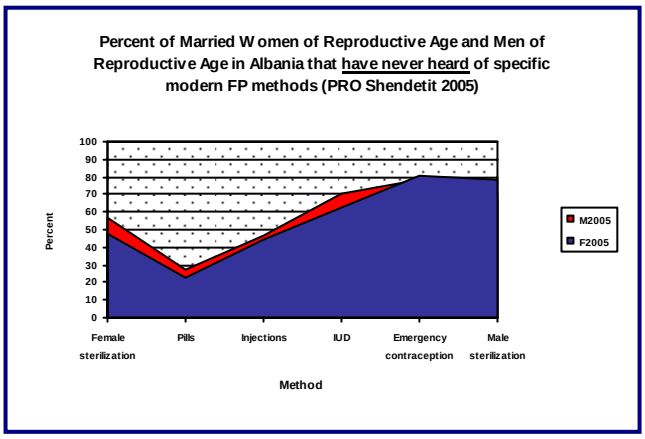
Knowledge and Use of Modern Methods of Contraception: 2002 and 2005 [35]

Evidence strongly suggests that knowledge and utilization of modern methods of family planning are changing in Albania – perhaps rapidly.



The Reproductive Health Survey of 2002 portrayed Albanian men and women as largely ignorant of modern methods of family planning. This lack of knowledge is portrayed in the graph to the right, showing the percent of men and women who said they had never heard of particular methods of family planning. The high levels of lack of knowledge, portrayed by the blue area for women and the even higher red area for men, were somewhat appropriately labeled as "mountains of ignorance."

It is difficult to believe that men were so ignorant of modern family planning methods and that 80 to 90 percent of them had not heard of most methods in the graph[36]. Other than female sterilization and oral pills, the vast majority of Albania women also had not heard of individual modern methods.



The recent PRO Shëndetit survey of three prefectures (Skhoder, Lezhe, and Korca) provides evidence that knowledge levels may be changing. It is important to state that the two samples are not statistically comparable.[37] The reproductive health survey was a national survey that included 3,709 married women of reproductive age. The PRO Shëndetit survey includes three prefectures and a sample of 1,327 married women of reproductive age. The two male samples are smaller but proportional in size to the women samples.

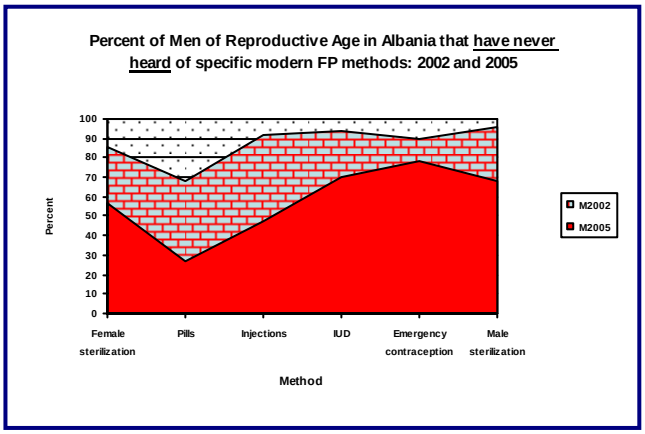
The value of the comparisons is because the PRO Shëndetit survey is more rural than the RHS (does not include Tirana) and knowledge and use levels of family planning are lower in rural areas. Consequently, aside from some type of major error in sampling or survey implementation, it is logical to expect less change in the more rural PRO Shëndetit

[35] "PRO Shëndetit: Two pager - Knowledge and Use of Modern Methods of Contraception: 2002 and 2005."

[36] It should be noted that condoms are not included in the graphs. Approximately 90 percent of men and women indicated they had heard of condoms.

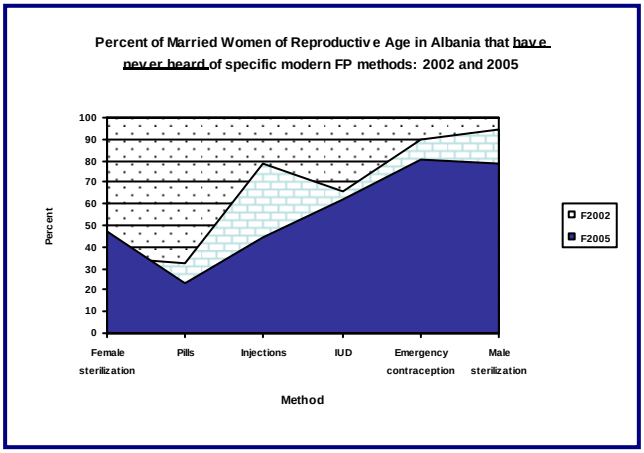
[37] The comparisons made here should be seen as preliminary, as the RHS data set will soon be available and will permit comparisons of the same sampled populations, i.e., the three prefectures in the 2005 survey

2005 survey than would be found the RH survey were currently repeated. It can be seen, especially for men, the level of ignorance about individual methods has, in general, decreased dramatically. Given the caveat, regarding the populations and samples, it is safe to conclude that the evidence suggests men and to some extent women indicate a greater awareness of modern methods in 2005 than they did in 2002.



It is possible to clarify this further by looking at the changes for men and women separately. The red area graph to the right shows levels of ignorance in 2002 by the grey shading and in 2005 by the solid red. The 2005 sample of men demonstrates a major decrease in ignorance of modern methods.

Although the differences for married women of reproductive age is not as great as the differences shown for men, the suggested general change can be seen in the blue area graph on the right. There has been a decrease in ignorance about all methods except female sterilization



The logical question is, if knowledge of methods has increased and knowledge is a first step in couples being able to make informed choices about using modern methods, what changes may have taken place in use of modern methods?

Survey	Area		
	Total	Urban	Rural
Reproductive health survey 2002	8	11.3	5.5
PRO Shëndetit survey 2005	15.2	23	10.6

Because different populations were sampled, results should be seen as general indications of direction and not the basis for precise comparisons. Keeping that caveat in mind, the table on the left provides the contraceptive prevalence rates (CPRs) obtained for total, urban, and rural sample areas. There is very strong evidence to suggest that the mountains of ignorance are lowering in Albania and that the utilization of modern contraceptive methods is increasing.

ANNEX E

PROGRAM REFERENCES

1. Framework for Transparency, Accountability, Prevention and Education

2. Anti-Corruption Model from Georgia

ANNEX E.1

POTENTIAL OF THE TRANSPARENCY, ACCOUNTABILITY, PREVENTION, ENFORCEMENT, AND FRAMEWORK (TAPEE)

An anti-corruption workshop for USAID/Georgia presented the TAPEE anti-corruption framework. An important advantage of the framework is that it "unpacks" the complex topic of corruption into detailed, positively-oriented opportunities for action. The following examples are specific ways to implement the TAPEE framework in health activities.

Transparency:
- Recognition of citizens, professional associations, and non-governmental organizations to advocate for better health services
- Wide dissemination of information on government health benefits
- Public announcements of major procurements of drugs, medical supplies, commodities and construction projects
- Transparent data and procedures at the hospital level, in particular, for the responsible stewardship of funds
- Public posting of fee schedules for services provided in health facilities
- Publication of national health accounts data to provide better understanding of who pays for what through whom in the health sector

Accountability:
- Establishment of self-governing professional associations such as Colleges of Physicians, Hospital Associations, and Family Group Practice Associations
- Creation of accreditation and licensing boards
- Adoption of evidence-based clinical and drug prescribing practices
- Separation of the purchaser and provider health care functions
- Establishment of drug formularies and essential drug lists
- Use of community health advisory boards and patient satisfaction surveys

Prevention:
- Various payment systems (e.g., case-based, capitation) to move payment for services from under the table to the top of the table
- Evidence-based treatment standards to ensure patients receive quality services
- Drug formularies so patients will receive more affordable drugs
- Various health insurance mechanisms, with safeguards against moral hazard, adverse selection, and "cream-skimming"

Enforcement:
- Establishment, or reform, of a licensing board to certify the quality of physician services
- Self-regulating accreditation board to ensure quality health facility services
- Regulatory board to monitor the operations of health insurance funds
- Passage and enforcement of patients rights legislation

Education:
- Media campaigns to explain the rationale and benefits of health reform programs
- Media coverage of corrupt acts and their impacts
- Public notices of organizations where citizens can seek assistance to address grievances with health care providers

ANNEX E. 2

MODEL OF ANTI-CORRUPTION EFFORT FROM GEORGIA

Presentation by Gabriela Paleru
E&E Health Managers Meeting,
Kiev, Ukraine, September 2005

Corruption =

Monopoly + Discretion

– Accountability

Omar Azfar, IRIS Center
(Klirgaard's formula)

Types of Corruption in Health

Area or Process	Types of Corruption and Problems	Indicators or Results
Construction and rehabilitation of health facilities	Bribes, kickbacks & political considerations Contractors fail to perform	High cost, low quality facilities and construction work
Purchase of equipment & supplies, including drugs	Collusion in bidding Kickbacks from contractors	Higher prices, low quality Reduce competition

Types of Corruption in Health

Area or Process	Types of Corruption and Problems	Indicators or Results
Distribution and use of drugs and supplies in service delivery	Theft / resale "Ghost" patients / recipients Sale of free drugs	Lower utilization Inadequate treatment Informal payments
Regulation of quality in products, services, professionals	Bribes to speed/gain drugs registration, GMP, influence quality inspection	Fake-drugs on the market Food poisoning Poor quality facility/provider

Types of Corruption in Health

Area or Process	Types of Corruption and Problems	Indicators or Results
Education of health professionals	Bribes to gain place in med schools/ passing grades	Incompetent professionals
Medical research	Pseudo-trials; informed consent misunderstood	Human rights violation Inequity in research
Provision of services by frontline health workers	Use of public facilities to see private patients; informal payments	Non cost-effective use of public facilities; reduce utilization by poor patients

Action to tackle drug selection?

Action	Likely Effects
Essential Drug Lists (EDL)	Limit influence /discretion of interest groups
Use Standard Treatment Guidelines as basis for EDL	Promotes transparency & accountability
Codes of ethics in marketing	May reduce unethical promotion activities
Pharmacy & therapeutic committees (hospital)	Public oversight Increased accountability
Indicator-based assessments & monitoring programs	Detect unusual selection and purchasing patterns

What to do on procurement?

Action	Likely Effects
TA to strengthen nat'l gov. capacity to manage competitive procurements	Promotes competition Limits and clarifies authority of government officials
Changes in how procurement officers are held accountable/paid	Provides better incentives, linked to performance
Public disclosure of inspection findings	Increases transparency
Rosters with performance ratings, lists of suppliers & price information	Limits discretion Improves accountability

ANNEX F

MID-TERM APPRAISAL
"IMPROVING PRIMARY HEALTH CARE IN ALBANIA"
"ALBANIA FAMILY PLANNING PROJECT"

1. **Statement of Work**
2. **Bibliography**
3. **Individuals Interviewed**

ANNEX F.1

STATEMENT OF WORK

Mid-term Appraisal of "Improving Primary Health Care in Albania"
"Albania Family Planning Project"

I. BACKGROUND

Health indicators in Albania were not especially good before the fall of the country's communist dictatorship in the early 1990's but they worsened as the clinical and preventive health care delivery system dramatically deteriorated during transition to a more open and competitive political system in the early 1990's. The rise of violent Balkan regional conflicts and domestic political turmoil over the decade compounded declines in the health system that had been brought on by sharp reductions in public sector investment. Despite improvements in the past few years, mortality and morbidity levels in Albania today remain higher than in all but a few countries in the southeastern part of the European region. That said, Albania's main health indicators are surprisingly better than would be predicted based n the country's very low socio-economic indicators and comparatively small financial allocations to the sector--a paradox to some observers.

Appraisals by USAID and other international agencies over the past decade have concluded that extensive legal, regulatory, financial, and programmatic reforms are prerequisite to raising health indicators to levels akin to those of neighboring Balkan countries. Most analyses conclude that severe financial constraints make large increases in public sector health investment unlikely, especially in view of limited absorptive capacities due to "inadequate management" of existing public resources. These appraisals generally prescribe or imply a steady increase in overall investment coupled with improved management.

The Government of Albania (GOA) has encouraged reforms, beginning with a national health insurance scheme launched in 1995. Fostered in part by assistance from UN/WHO, World Bank, USAID, Italy, and Greece, the Ministry of Health developed and, in 2004, the Council of Ministers approved a ten-year health strategy with Primary Health Care (PHC) as the foundation for health system reforms. This strategy has yet to be approved by parliament.[38]

Increasing GOA spending for health is beyond USAID's ability to directly influence and, in any case, greatly increased social sector spending is unlikely given the country's macro-economic and fiscal realities. USAID's strategy therefore aims to increase the cost-effectiveness of present resource allocations. The approach aims to acquire understanding of health care financing realities sufficient to help the GOA test more efficient ways to invest in the sector, particularly in PHC. It aims to promote operational models that increase capacities to absorb more public finance based on higher quality of, and greater public demand for, primary and preventive services. Complementary World Bank and related other agency external financing also are intended mid-term results of USAID's approach.

Albania's demographic transition from relatively high fertility in the late 1980's to levels converging with replacement fertility in the mid-2000's arguably has been the most dramatic ever recorded in Europe. Albania's present age pyramid reveals that by far the largest age group are those aged 16-25. Extensive research shows that couples have achieved this fertility reduction due in great measure to widespread access, after 1991, to safer abortion services as a

[38] Elections in July '05 changed the party coalition in majority; a new government could be in place by September. The coalition leader will be a cardiologist and medical professor whose background may have positively influenced GOA health policies and programs when he was President of Albania from 1992 through 1997. SO3 ventures no guesses about the implications of the July elections for GOA health programs and expects no particular or significant shifts in GOA health strategy.

back-up to withdrawal (*coitus interruptus*)--not due to rapid growth in use of modern contraception.

USAID, however, has provided extensive family planning assistance in Albania since the mid-1990's, mainly with intent to reduce reliance on abortion. This assistance has evolved from an initial focus on contraception and family planning, to improving services for contraception in the context of additional reproductive health services (e.g., basic reproductive tract and sexually transmitted disease prevention), to a current primary health care focus (e.g., addressing mother and child health issues). Use of modern methods of contraception is increasing in Albania but the evolution so far seems slow; by 2002 no more than nine percent of couples likely were using a modern method and abortion rates remained stubbornly high at perhaps 200 per 1000 live births.

USAID's current Strategic Plan 2001-2004, extended through 2006, identified and addresses these critical impediments to improved health care in Albania:

- *Inefficient use of scarce resources* in an environment unlikely to produce meaningful increases in public funding for health services *(IR 1);*
- *Quality of health services* so poor that they are not responsive to needs of vulnerable populations and may even foster public disdain for the PHC system *(IR 2);*
- *Low use of PHC services* resulting from lack of public awareness and confidence in and limited availability of quality PHC services *(IR 3).*

These constraints form the basis of the Mission's contracted technical assistance which at present mainly engages two US-based organizations:

(1) University Research Co. (URC; with Bearing Point): Mission-based contract, "Improving Primary Health Care Services (*Pro Shëndetit*)": *(IR1, IR2, IR3). Pro-Shëndetit* began in September 2003 and the present contract extends through August 2006, with the option to extend for one or for two years.

(2) John Snow, Inc. (JSI; with Manoff Group): USAID/GH Task Order, "Albania Family Planning Project (AFPP)" 2004-2006: *(IR2, IR3).* The AFPP will conclude it activities in September 2006.

To enhance operational efficiency and synergies for results, since their primary health care activities often are related, in late 2004 the Mission encouraged the two groups to more closely share in planning and—to the extent feasible and consistent with terms of their contracts —in implementation and results reporting.

USAID/Albania will start new strategy development in late 2005. The Mission also must soon decide on its options for extension of the URC/*Pro Shëndetit* contract. A mid-term appraisal of its SO3 contract configuration, therefore, is needed and timely.

II. SCOPE OF WORK

The appraisal will engage three USAID-experienced health and family planning specialists to review the Mission's SO3 – Health strategy, examine progress of the two SO3 contracts, and advise on extension and/or adjustments to URC/*Pro Shëndetit* and any adjustments to JSI/AFPP for the concluding months of this activity. It should include practical recommendations for performance improvement and future Mission strategic planning.

1. Impacts

Pro Shëndetit had a very slow and difficult start-up. Over recent months, however, there has been a rapid roll-out of activities that are meeting and in some instances exceeding expected results (e.g., clients receiving training, health centers enrolled in quality improvement). The appraisal should address these questions:

- To what extend has the GOA (MOH, Health Insurance Institute [HII], Local Government) benefited to date from the health financing interventions designed by the *PRO Shëndetit* project.[39]

- How many existing health posts assisted by the project likely have verifiably improved management skills and to what extend are those skills being applied?

- What is the team's assessment of the quality of the new health information system and whether these changes are likely to impact the local and national health system?

- Are there adequate tangible impacts of the project's credit assistance and training (especially with regard to quality assurance functions and clinical skills of health providers at beneficiary health post)?

- Are there adequate positive changes in the "attitude" of health institutions with regard to licensing accreditation and certification?

- To what extent has the project likely helped increase access to and use of selected PHC services by women/children and other vulnerable groups?

- Have AFPP activities significantly improved demand for modern methods of contraception and/or increased access to quality family planning services? Does it seem likely that AFPP actions will do so before the activities end in 2006?

2. Project Design, Implementation Strategy, and Operation

and AFPP are testing an hypothesis that in Albania poor resource management, poor quality of services and limited access to and use of PHC services are fundamental constraints to the development of cost-effective PHC and improvement of basic health indicators, about which, skillful assistance can make a positive difference. Has the project experience in the past two years validated this hypothesis? Based on project experience, what aspects of design and implementation strategies should be (or should have been) revised?

- Is the design of the project based on sound problem analysis? Are the expected results and objectives realistic (or modest) with regard to USAID contract resources? Should the expected results be revised to better measure the impact of the project?

- Are implementation strategies and approaches appropriate for achieving project objectives? Do they help achieve project objectives in the most efficient (cost-effective) manner? If not, what are better alternatives?

[39] Through USAID, Abt Associates' "Partners for Health Reform*plus* Project" (see Bibliography) was prominent in Albania's health system assessments and reform from February 2003-March 2005, assisting in health financing and government decentralization focused on PHC and based mainly on health information and reporting, via four model PHC clinics in four sites of Berati District. This largely successful SO3 component closed as scheduled in March 2005 and PHR+ legacies were incorporated into *ProShëndetit*, significantly enhancing health financing and PHC elements in URC's contract portfolio. Review of URC's present contributions under its contract should take this evolution into account.

- Have implementation strategies been accurately and efficiently translated into operations?

- Is the timeframe of project implementation realistic for long-term sustainability?

- In view of the Agency plan to review a new, preliminary USAID/Albania Country Strategic Plan by May 2006, what are the team's recommendations regarding the Mission's options to extend activities *up to* September 2008?

III. TIME AND PERSONNEL REQUIREMENTS

The evaluation team will consist of: 1) a health reform/system strengthening specialist, serving as the team leader; 2) a service delivery/reproductive health specialist; and 3) a health policy and finance specialist. The USAID/Albania SO3 team assistant is available to assist in communication with non-English speaking Albanians and otherwise facilitate team work on-site.

Work in Albania should start on/about September 19, 2005 and continue through on/about October 8, 2005. Roughly three weeks in-country for one, two, or all of the team is sought, especially the team leader.

A six-day work week will be authorized. The total number of work days for each of the team members shall not exceed 28 work days. Up to four days of travel to and from Albania are authorized for each team member.

IV. RELATIONSHIPS AND RESPONSIBILITIES

The evaluation team shall work under the technical direction of the USAID/Albania Health Officer/CTO, Zhaneta Shatri, who will be responsible for all coordination with the Government of Albania. The team leader will be responsible for arranging and coordinating field logistics and schedules directly with the local contractors. Periodic meetings between the CTO and the Mission's Program Officer, David Thompson, will be held for progress monitoring and adjustments to the appraisal team work plan and report outline.

The Mission's SO3 Health Advisor will not likely be present during this period but will be virtually included in as much of the reviews as feasible with communications coordinated by the CTO. Final approval of deliverables rests with the Program Officer.

V. DELIVERABLES

No later than three days after the team's arrival in Tiranë, the team leader shall present a team work plan and detailed outline of the appraisal report. The outline shall be based on the statement of work above as adjusted by discussions between the appraisal team and the SO3 Team and on-site inputs from the Mission Director and Program Officer. A draft report in English including major findings, conclusions, and recommendations shall be submitted to the CTO four days before the team's departure with an oral briefing on the draft report the following day, at which time USAID/Albania will provide comments to be addressed in the final document. Prior to the team's departure, a completed draft of the report .

ANNEX F.2

BIBLIOGRAPHY

1. Government of Albania, Ministry of Health, April, 2004, "The Long-Term Strategy for the Development of the Albanian Health System" (hard copy available at Mission).

2. Government of Albania, Ministry of Health, "Albania National Health Accounts", 2003.

3. Government of Albania, Ministry of Health, Albania Reproductive Health Survey 2002, Final Report (Draft), May 2005 (hard copy available at Mission)

4. Government of Albania, Government Program, 2005-2003, Presented in the Albanian Parliament, by the New Government headed by Prime Minister Mr. Sali Berisha, in Tirana, September 9, 2005

5. Government of Albania, Institute of Statistics (INSTAT), Albania, http://www.instat.gov.al [e.g., *Shqipëria në shifra*] Albania in Figures and 2000 Census

6. U.S Mission to Albania, Mission Performance Plan FY 2007

7. USAID/Albania, Strategic Plan for 2001 -2004

8. USAID/Albania, Revised Strategic Plan for 2001-2004 (extended through 2006)

9. USAID/Albania, Strategic Revalidation Exercise, SO3-Health Excerpt, 2004

10. USAID/Albania Contract No. 182-C-00-03-00105-00, "Improving Primary Health Care in Albania" (University Research Corporation.--URC). August 2003

11. USAID/Global Health Contract GHS-I-00-03-00026-00 Task Order II (#802), "Albania Family Planning Activity," (John Snow, Inc with the Manoff Group), September 2004.

12. USAID/ Bureau for Europe and Eurasia, Health Vulnerability Analysis, October 2005

13. USAID/Bureau for Europe and Eurasia, Address of the Assistant Administrator, Kent R. Hill to the Participants at the E&E Health Managers Workshop, May, 2004

14. *PROShëndetit*: Improving Primary Health Care in Albania – Updated Performance Management Plan, University Research Corporation, 8 July 2005

15. *PROShëndetit*: Baseline Survey Results, University Research Corporation, January 2005.

16. *PROShëndetit*: Three-Years Strategic Plan, August 2003-August 2006, University Research Corporation, September 2004

17. *PROShëndetit*: Response to "Questions for University Research Corporation from the USAID Assessment Team, Written Communication, September, 2005

18. *PROShëndetit*: Two page Briefers, September 2005
    - Health Financing Activities
    - New Health Information System in Albania
    - Quality Improvement at Health Center and Health Posts
    - Quality Improvement – From Multiple Directions
    - Health Promotion
    - Knowledge and Use of Modern Methods of Contraception: 2002-2005
    - Monitoring and Evaluation

19. *PROShëndetit*: Quarterly, Annual, and Ad hoc Contract Reports from University Research Corporation, 2004 – 2005

20. Albania Family Planning Program, Quarterly, Annual, and Ad hoc Contract reports from John Snow, Inc., 2004-2005

21. Albania Family Planning Program, Integrated Family Planning Activity, Trainer's Guide and Curriculum, John Snow, Inc. 2005

22. Albania Family Planning Program, Participatory Training Techniques, Trainer's Guide and Curriculum, John Snow, Inc. 2005

23. Albania Family Planning Program, Laurie Krieger, Survey and Ethnographic Study of Albanian Couples Views about and Use of Fertility Regulation: for Albania Family Planning Project Behavior Change Strategy; Manoff Group and JSI, July 2005

24. Albania Family Planning Program, Response to "Questions for John Snow, Inc. from the USAID Assessment Team, Written Communication, September, 2005

25. Technical Assistance to Improve Access to Quality Reproductive Health Services for the Albanian Women. Final Technical Report: Strengthening Key Components, John Snow, Inc. September 2003

26. Partners for Health Reform*plus*, "Costs and Utilization of Primary Health Care Services in Albania: A National Perspective on a Facility-level Analysis," Abt Associates Inc., June 2004,

27. Partners for Health Reform*plus*, "Primary Health Care Reform in Albania: A Pilot Project to Provide Evidence for Health Policy," Abt Associates Inc., February 2005

28. Partners for Health Reform*plus*, "Primary Health Care Reform in Albania: Baseline Survey of Basic Health Service Utilization, Expenditures, and Quality, Abt Associates Inc., February 2004

29. Partners for Health Reform*plus*, Albania Highlights, Abt Associates Inc, August 2003; December 2003; February 2004; and June 2004

30. Jorge Scientific Corporation with the Futures Group, Albania, Country Profile and Statistical Data, June 2005

31. World Bank, Country Assistance Strategy for the Republic of Albania (Draft), November 2005

32. World Bank, Policy Notes for the Government of Albania, Health Sector Reforms, Compiled from Donors Comments, September 2005

33. World Bank, Health Sector Mission *Aide-Mémoire*, June 2004.

34. World Bank, The Burden of Disease among the Global Poor: Current Situation, Future Trends, and Implications for Strategy, Davidson Gwatkin and Michel Guilott, 2000

35. World Health Organization, Comments on Health Financing Draft Laws: Report of a WHO Mission to Albania (Couffinhal/Evetovits), September 13-19, 2004

36. World Health Organization, Externally Financed Programmes in the Albanian Health Sector, 2004

ANNEX F.3

INDIVIDUALS INTERVIEWED

USAID/Albania
Harry Birnholz, Director
David Thompson, Program Officer
Zhaneta Shatri, Health Office and Program Cognizant Technical Officer
Gary Merritt, Health Advisor, Personal Services Contractor
Michael Stewart, Executive Office
Richard McLaughlin, Consultant to USAID/Albania on Strategic Planning

***PROShendetit* (URC with Bearing Point, and American Association of Family Physicians**
Richard Sturgis, Chief of Party
Zamira Sinoimeri, Deputy Chief of Party (newly appointed Deputy Minister of Health)
Paul Thim, Health Financing Expert
Altin Malaj, Monitoring and Evaluation Officer
Erion Dasho, Health Management Information Specialist
Flora Hobdari, Health Finance/Health Reform Specialist
Sokol Kaso, Logistic and IT Officer
Dorina Tocaj, Health Promotion Specialist
Ornela Palushaj, Project Coordinator
Zhenien Zanaj, Technical Assistant
Marcel Reyners, Service Delivery Specialist
Altin Azizlari, Health Management Information Specialist
Aferdita Gjoni, "*PROShendatit*" Project Coordinator in Lezha

Albanian Family Planning Project (John Snow, Inc. and Manoff Associates)
Manuela Murthi, Project Director
Eduard Goga, Behavior Change and Communication Officer
Gazmend Koduzi, Training Officer
Agim Kasaj, Finance, Logistics Management and Information System Officer
Patrick Dougherty, Senior Advisor (home office)

Health Insurance Institute of Albania
Albert Kola, Director of Information Department & Statistics Analysis
Diana Ristani, Economic Director
Laureta Mano, Legal Department
Ardiana Ristani, Economic Department
Besnik Bruci, Reimbursement Department
Albana Adhami, Medical Department

Ministry of Health of Albania
Ilia Pecani, Director of Public Health, Public Health Directorate
Emil Como, Chief of Ambulatory Services, Public Health Directorate
Nedime Ceka, Chief of Reproductive Health Sector,

Institute of Public Health, Ministry of Health
Silva Bino, Director

BERAT District
Ibrahim Sado, Head Doctor and staff, Health Center in Ura Vajgurore
Ali Gjolena, nurse, Health Post in Roma Neighborhood (Morava)
Donika Papa, Head Doctor and staff Health Center in Muzaka:

Dashuri Beqiri, Head of Clinic (nurse), Family Planning Clinic
Edlira Shkembi, Head of Center (OBGYN) Mother Counseling Center:

KORCA District
Director of Primary Health for Korca
Liljana Ballco, Inspector of Mother and Child Health Services
Anila Morava, Family Planning/Maternity Center, Maternity Hospital
Lumturi Veliterna, Pediatrician, Maternity Hospital
Anita Hysenlli, Nurse, Urban, Health Center nr.2
Dr.Sashenka Cenko, Chief of the Urban Health Center
Skender Veizi, Clinic Patient
Ruzhdi Keco, Family Doctor, Health Rural Pojan
Biko Kelo, Midwife, Pojan Health Center
Zhani Kelo, Midwife/Part of Health Promotion Teams, Pojan Health Center

LEZHA District
Fatmir Dushkaj, Director, Primary Health Care for Lezha
Davida Smaci, Chief Nurse, Urban Health Center
Zoja Zefi, Physicain Trained in COPE and Management Information System. Lezha Urban Health Center
Marije Sheri, Family Doctor, Urban Health Center
Najada Koleci, Nurse, Urban Health Center
Etleva Marku, Nurse in Family Planning, Women Wellness Center
Liljana Gjoni, Chief Nurse, Women's Wellness Center
Ndue Prenga, Chief of Health Center, Shenkoll
Martine Marku, Nurse, Shenkoll Health Center
Flora Deda, Health Promotion Unit, Shenkoll Health Center
Mirela Ndoi, Health Promotion Unit, Shenkoll Health Center
Vitore Dukati, Nurse, Shenkoll Health Center
Diella Gjini, Community Health Educator, Shenkoll Neighborhood

UNICEF
Carry Auer, UNICEF Representative
Mariana Bukli, Health Specialist

World Bank Liaison to the Ministry of Health
Saimir Kaiu

World Health Organization (WHO)
Santino Severoni, Country Office Director
Serap Sener, Project Manager